The *Fatality Inquiries Act*: A Discussion Paper

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FATALITY INQUIRY AND CORONERS LEGISLATION REFERRED TO IN THIS PAPER

Alberta, *Fatality Inquiries Act*, R.S.A. 1980, c.F-6 as amended to September 2, 1997 referred to as the Alberta act, statute or legislation.

British Columbia, *Coroners Act*, R.S.B.C. 1979, c. 68 as amended to July 1, 1990 referred to as the British Columbia act, statute or legislation.

Manitoba, *Fatality Inquiries Act*, S.M. 1989-90, c. F52 referred to as the Manitoba act, statute or legislation

New Brunswick, *Coroners Act*, R.S.N.B. 1973, c. C-23 referred to as the New Brunswick act, statute or legislation

Newfoundland, *Fatalities Investigations Act*, S.N. 1995, c. F-6.1 referred to as the Newfoundland act, statute or legislation

Northwest Territories, *Coroners Act*, R.S.N.W.T. 1988, c. C-20 referred to as the Northwest Territories act, statute or legislation

Nova Scotia, *Fatality Inquiries Act*, R.S.N.S. 1989, c. 164 referred to as the Nova Scotia act, statute or legislation

Ontario, *Coroners Act*, R.S. O. 1990 referred to as the Ontario act, statute or legislation

Prince Edward Island, *Coroners Act*, R.S. P.E.I. 1988, c. C-25 referred to as the Prince Edward Island act, statute or legislation

Quebec, *Determination of the Causes and Circumstances of Death Act*, R.S. Q. R-O.2 referred to as the Quebec act, statute or legislation

Saskatchewan, *The Coroners Act*, R.S.S 1978, c. C-38 referred to as the Saskatchewan act, statute or legislation

Yukon Territory, *Coroners Act*, R.S.Y. 1986, c. 35 referred to as the Yukon act, statute or legislation

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1. INTRODUCTION

There have been a number of complaints about the *Fatality Inquiries Act* in the past dozen years. The qualifications of the former Chief Medical Examiner for Nova Scotia were criticized by the police; some members of the Provincial Court complained about the amount of time and money being spent on inquests which they believed to be of limited usefulness; the constitutionality of clause 16(1)(b) of the Act was challenged on the grounds it invaded the federal criminal power; and most recently, the adequacy of the statute was questioned in the context of the events associated with the death of a QE II Health Sciences Centre patient and the subsequent charging of a physician with first degree murder.

Since 1989, the Act has been amended three times producing changes in five sections. In many ways, the Act neither provides a framework for the modern purpose of a death investigation system nor reflects current practices in a number of areas. Currently, it is being reviewed for the purpose of law reform, and this paper is provided as background information about the Act and as a means of identifying some of the main issues that require policy decisions. Through a consultation process with those who have an interest in a well-functioning death investigation system, the Department seeks suggestions for the revision of the Act and constructive criticism of the material presented in this paper.

2. PURPOSE OF DEATH INVESTIGATION LEGISLATION

Our society places a high value on human life, and death investigation legislation provides a mechanism whereby categories of deaths that appear to be "unnatural" may be investigated and explained. An understanding of how a death occurred may lead to the prevention of similar deaths in the future, and "public accountability" may be promoted through the scrutiny of "the operations of public institutions and agencies when sudden or suspicious deaths occur". [1]

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[1] Ontario Law Reform Commission. *Report on the Law of Coroners.* (Toronto: The Commission, 1995) at p.4.

2.1 Coroners and Medical Examiners Contrasted

In the Anglo-American world, there are two systems of death investigation: the coroner system and the medical examiner system. The coroner's primary function is to conduct a judicial inquiry known as an " inquest" into a death. The medical examiner's is to reach a conclusion on the cause of death based on an assessment of the deceased's medical history and external or internal examinations of the deceased. The ability to ascertain the cause of death from a medical perspective is fundamental to the death investigation system.

While there are coroner systems that are highly effective death investigations systems, for example in Ontario where the coroners are physicians, most of the legislation governing these systems in Canada continues to reflect, in part, its long connection with the criminal justice system, a role no longer accepted within Canadian law. It would appear that the sensible choice for Nova Scotia is to reform the existing medical examiner system. It is on this assumption that the issues are presented in this document.

2.2 Coroner System

The coroner system is believed to have been established in England at least 800 years ago when its fundamental purpose was the preservation of law and order. Policing, as we know it, is a comparatively modern institution, and for the most part, it fell to the residents of a community to maintain order. In mediaeval England, "Most coroners' inquests were held on homicides and deaths by misadventure, but, from the earliest times, a coroner was also expected to make inquiries when death was sudden or unexpected, when a body was found in the open and the cause of death was unknown and when a death occurred in prison".[2] Where a person found a body, a "hue and cry" was raised and the coroner had to be notified immediately. The body had to be viewed by the coroner and "speed was important if he were to have any chance of apprehending a suspect". The coroner's

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[2] Paul Knapman and Michael J. Power,s, *The Law and Practice on Coroners: Thurstons Coronership*, 3d ed. (Chichester, Barry Rose, 1985) at §1.08 (p. 2):

jury also viewed the body, and after hearing from witnesses (who were sometimes the jurymen themselves) the jury would deliver a verdict stating how the person had died, and, if it was believed there was foul play, who was responsible. This verdict was written out in a document known as an "inquisition", and on the strength of the inquisition, a person identified by the jury as responsible for the death could be arrested and jailed.

Not only was the behaviour of individuals investigated by the coroner's inquest, but the conduct of the entire community could be scrutinized and if "the men of the neighbourhood" were found to have "failed in their duty", the town or neighbourhood was punished with a stiff fine known as an 'amercement'."[3]

Until this day, the inquest and its inquisition have remained a part of the criminal justice system in many places, but not within Canada. In a number of American jurisdictions[4], the inquest continues as "an investigative tool designed to aid in the detection of crime", where it functions to:

> ascertain the nature of the cause of the death, and, in cases of death by violence or other undue means, to obtain and secure evidence for the use of those charged with the detection and prosecution of crime.[5]

The American legal encyclopaedia *Corpus Juris Secundum* states that a coroner's inquisition is "the equivalent of a finding by the grand jury, and is a sufficient basis for a prosecution of murder or manslaughter."[6] As an example, under Florida law (which has a medical examiner system under one

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[3] Paul Knapman and Michael J. Powers, *The Law and Practice on Coroners; Thurston's Coronership*. 3d ed. (Chichester, Barry Rose, 1985), §1.04.

[4] In the United States, 11 states operate with coroner systems, 18 with mixed systems (that is, some districts or counties of a state may have coroners while others have medical examiners) and 22 states operate with medical examiner systems: *see* D. L. Combs, R. Bison Parrish, Roy Ing, *Death Investigation in the United States and Canada, 1995*. Atlanta: U.S. Department of Health and Human Service, Public Health Service, Centers for Disease Control and Prevention, August 1995, Table 2a at p. 13.

[5] 18 *Corpus Jurus Secundum* §10.

[6] 18 *C.J.S.* §20, Effect of verdict.

statute and an act respecting inquests under another) the only time an inquest is called is when there is a "question of the occurrence of a criminal act, criminal negligence, or foul play associated with the death".[7]

In Canada, criminal objects no longer form the basis of coroner systems: the *Criminal Code*, s. 576(3) has, since its initial release in 1892, forbidden an individual being "tried on a coroner's inquisition"; the *Constitution Act, 1867*, s. 91(27) precludes a province legislating in respect of criminal law; and a finding of criminal responsibility at an inquest would be contrary to s. 91(27) and the *Charter of Rights and Freedoms*.

In Canada, there are coroner systems in British Columbia, New Brunswick, the Northwest Territories, Ontario, Prince Edward Island, Quebec, Saskatchewan and the Yukon. Only in Ontario and Quebec are coroners medically qualified.

2.3 Medical Examiner Systems

Medical examiner systems of death investigation are said to have arisen in the United States in the nineteenth century as a reform of the coroner system.

In Canada, medical examiner systems exist in Alberta, Manitoba, Nova Scotia and Newfoundland. It is expected that the medical examiner, who is a physician, will bring "medical expertise to the evaluation of the medical history and physical examination of the deceased".

In some instances, a medical examiner may also be a pathologist whose qualifications include the conduct of autopsies. Some medical examiners, such as the current Chief Medical Examiner for Nova Scotia, are qualified as forensic pathologists. Their expertise has been described in this way:

> The forensic pathologist is an expert in determining cause and manner of death. The forensic

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[7] *Inquests of the Dead Act*, 936.00.

> pathologist is specially trained to perform autopsies to determine the presence or absence of disease, injury or poisoning; to evaluate historical and law-enforcement investigative information relating to manner of death; to collect medical evidence, such as trace evidence and secretions to document sexual assault; and to reconstruct how a person received injuries. Forensic pathologists are trained in multiple non-medical sciences as well as traditional medicine. Other areas of science that the forensic pathologist must have a working knowledge of the applicability of are toxicology, firearms examination (wound ballistics), trace evidence, forensic serology and DNA technology....[8]

In some U.S. jurisdictions, the services of medical examiners' offices have been extended to include a number of social services. For example, in one county in the state of Washington, the medical examiner's office offers counselling regarding the manner and cause of death to family members who are "having a difficult time understanding the cause of their loved one's death and may have questions on the manner of death and circumstances surrounding the death". The office will also refer individuals to organizations offering grief counselling. Under the heading "forensic services" , the office will clarify "medical terminology on autopsy reports and death certificates ..." and also provide "information regarding testing for HIV exposure, paternal testing, DNA testing, death certificate information, funeral home information, information on cleaning services following a traumatic death, private autopsy referrals, and death investigation training referrals." The office also provides "notification to family members of a loved one that has died". These services are provided at no charge. Forensic consultations, such as interpreting the wounds of a living person, are available at a fee.[9]

Just as coroner systems cannot have a criminal purpose under Canadian constitutional law, neither can a medical examiner system. In Canada, the detection of crime is an important result of the work of a coroner or a medical examiner. It is a product of the system, however, rather than its primary purpose.

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[8]National Association of Medical Examiners, "So you want to be a Medical Detective?" Brochure

[9]Pierce County Medical Examiner's Office, Tacoma, Washington. Medical Examiner's Office -- Services: www.co.pierce.wa.us/services/lawjust/sermed.htm.

3. CAUSES OF DEATH IN NOVA SCOTIA

Every year in Nova Scotia, more than 7,600 people die. Death comes to most -- 95 percent or more than 7,200 individuals -- as a result of disease. Of the remaining five percent, about 288 will die as a result of an accident; another 105 or so will take their own lives. Far less than one percent of the total deaths each year -- an average of 17 individuals -- die following an assault. These averages are based on the information set out in Table 1 for the period 1992-1995.

Table 1
Causes of Death: Nova Scotia, 1992-1995

Cause of death	1992	1993	1994	1995
Accidental deaths	308	292	266	288
Assaults	21	17	14	16
Misadventures during medical care, abnormal reactions, late complications	12	7	10	9
Suicides	97	107	97	122
Disease	7,106	7,136	7,382	7,244
Total deaths	7,544	7,559	7,770	7,687

Source: Nova Scotia, Business and Consumer Services, *Vital Statistics Annual Reports 1992,1993, 1994,1995*, Table X.

It is striking that suicide claims as many victims as motor vehicle related deaths. Another significant number of people died as a result of falls and fractures though the data is not collected in a manner that allows us to distinguish a fall in the workplace from a fall causing a broken hip in an elderly person. A detailed listing of the five percent of total deaths that are <u>not</u> caused by disease is found in Appendix A, Table A.

As the largest concentration of population in the province is found in the Halifax Regional Municipality, more people --in absolute numbers -- die in Halifax County than in any other part of the province.[10] However, standardized mortality rates by county for the period 1990-1995 show that

[10] Nova Scotia, Business and Consumer Services, *Vital Statistics Annual Report 1994*, Table X, p 65.

death due to accidental and adverse effects is highest in Victoria and Digby counties. The highest rate of death in the province for all causes of mortality is found in Cape Breton county.[11]

4. HISTORY OF CORONER AND MEDICAL EXAMINER LEGISLATION IN NOVA SCOTIA

4.1 From inception to 1894

The coroner system of death investigation would have been received in Nova Scotia with British colonization. The first reference to a coroner in a Nova Scotia statute is found in a 1787 Act, which established the coroner's fee for "taking an Inquest" at 20 shillings, and provided that the fee might be taken "out of the deceased's estate" where there was one, and from the county treasury where there was not. It would appear that the coroner was also responsible for the burial of the deceased where he or she had "no goods or effects to discharge the expenses of burying" . He would be reimbursed 20 shillings by the province for this service providing "the interment is certified by the Justices in Session to have been decently performed".[12]

A little more than 40 years later, in 1828, a more detailed Act "relating to Coroners and their Fees" directed that coroners were to be paid 50 shillings from the "Treasury of the Province" upon the filing of a Certificate with the Secretary of the Province. The certificate was issued to the coroner by the Clerk of the Crown when he filed the Inquisition with the Clerk. Out of the 50 shillings, the coroner was required to pay the jury's fees, and the constable's fees. The Act codified the coroner's authority to summon a jury, and stated that inquests could be held on Sundays if need be. It also stipulated that if the coroner had to look after the burial, the costs were to be "defrayed by the County

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[11] www.gov.ns.ca/health

[12] S.N.S. 1787, 28 Geo. 3, c. xv, s.4, "Coroner's Fees".

or District wherein such Inquest was taken provided that an account of items be rendered by the Coroner ... to the Court of General Sessions of the Peace, and approved of by the Grand Jury in the usual manner".[13]

Chapter 41 of the Revised Statutes of Nova Scotia, 1851 entitled "Of Coroners", was expressed in plain language style presentation and added two provisions to the 1828 Act. Section 1 stated that coroners "may be appointed by the governor in council, and shall be sworn" before a judge before taking office, requirements which appear for officer holders under the present *Fatality Inquiries Act*. Also, under Section 7, coroners were directed to return "lists in triplicate of the inquests held by them, together with the findings of the juries to the board of statistics" before January 10th of each year or else they would be penalized £5. This "board of statistics" was the precursor of the Vital Statistics office, and there continues to be an ongoing relationship between the successors of the coroners, the medical examiners, and this office which is reflected in the *Vital Statistics Act*.

In the 1873 consolidation, the act respecting coroners appeared as Chapter 19, and under Section 7, justices in session had authority to "amerce" a county to cover the expenses of burials or the extraordinary costs of inquests. (This had disappeared by the 1884 revision.[14]) This Act also allowed for the payment of the fees of "medical men examined before a Coroner's Jury". The fee, set at $5.00, was inclusive of a fee for "a *post mortem* examination if made": s. 5.

4.2 Medical Examiner in Halifax and Dartmouth: 1895

In 1895, there was a significant change to death investigations in the Halifax - Dartmouth area when *An Act to amend the law respecting Coroners*[15] was passed by the House. The new legislation cancelled the "commissions of all coroners for the county of Halifax who reside in the city of Halifax

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[13] *An Act relating to Coroners' and their Fees*, S.N.S. 1828, Geo.9 XVI.

[14] R.S.N.S. 1884, c. 17.

[15] S.N.S. 1895, c. 15.

or in the town of Dartmouth", nullified their powers and stated they had no more authority to act: s. 1. In their place a "Medical Examiner for the city of Halifax and town of Dartmouth" was appointed who was required to be a "duly licensed and registered practitioner in medicine and surgery": s. 2. When the legislation was presented to the House on second reading, the Hon. Mr. Fielding stated that "it was well known that for some time past there had been some dissatisfaction in the public mind with regard to the operation of the law respecting coroners, chiefly in the city of Halifax". He continued:

> Instead of a coroner, the bill provided for a medical examiner, whose duty it would be to take examinations in a summary way in cases that might be brought before him. In probably five cases out of six in which coroners' inquests are held it was evident that there was no great necessity for them, but of course it would not be wise to dispense with any investigation. In a large proportion of such cases a summary investigation was all that was necessary, and an elaborate investigation sometimes degenerated into something of a farcical character...
>
> The government realized the fact that there were special cases of a grave character in which a judicial investigation as to the cause of death should be held. In such special cases the bill provided that the medical examiner should report to the stipendiary magistrate of Halifax or Dartmouth, and the magistrate would undertake to hold a judicial enquiry ... [16]

4.3 *Medical Examiner (Halifax and Dartmouth) (1900) Act* and *Coroners' Act (1900)* Contrasted

In the Revised Statutes of 1900, the 1895 medical examiners' statute appeared without the transition clauses as *The Medical Examiner (Halifax and Dartmouth)Act* : R.S. 1900, c. 37.[17] It immediately followed the *Coroners Act*, R.S. 1900, c. 36 in the statute book.

When the two pieces of legislation are compared, it is seen that the authority of the medical examiner arose just as the coroner's did, when he was "informed that the dead body of a person is lying within the limits of his jurisdiction" and there was reason to suspect death by violence,

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[16] *Debates and Proceedings of the House of Assembly* , February 22, 1895, at p.63.

[17] In 1909, *An Act to Extend the Provisions of Chapter 37, Revised Statutes to the City of Sydney*, S.N.S. 1909, c. 16. legislation was passed extending the *Medical Examiners (Halifax and Dartmouth) Act* to the city of Sydney. It would appear that it was never proclaimed.

undue means, or culpable negligence, or that the person had died in prison: *Coroners' Act*, s. 3(1); *Medical Examiner (Halifax and Dartmouth) Act*, s. 6.

What happened next differed. The coroner had to summon a jury and hold an inquest, and at the first sitting "view the body": *Coroners' Act*, s. 3(1),(3); s. 5. In contrast, the medical examiner was instructed to go to where the body was, take charge, inspect the body and "make diligent inquiry respecting the cause and manner of the death": *Medical Examiner (Halifax and Dartmouth) Act*, s. 6. The coroner's jury, after hearing the witnesses, produced an "inquisition in writing stating ... who the deceased was, and how, when, and where the deceased came to his death, and the persons, if any, whom the jury find to have been in whole or in part responsible for his death": *Coroners' Act*, s. 5(3). The medical examiner "reduce[d] to writing every circumstance respecting the condition of such body and tending to show the cause and manner of the death of such person, together with his own opinion as to the cause of such death": *Medical Examiner (Halifax and Dartmouth) Act*, s. 6.

At the conclusion of the inquest, the coroner "return[ed] the inquisition ... together with the depositions of the witnesses, to the clerk of the Crown...": *Coroners' Act*, s. 7. The medical examiner filed his "writing" with the "clerk of the Crown ...": *Medical Examiner (Halifax and Dartmouth) Act*, s. 6.

Where the medical examiner was of the opinion that the "death was caused by violence, undue means, or culpable negligence, or that there is reasonable ground for suspecting the same", he had a duty to send a copy of his report to the stipendiary magistrate for Halifax or Dartmouth (depending in which place the body was found): *Medical Examiner (Halifax and Dartmouth) Act*, s. 9. Once the magistrate received this report, he was required to hold an inquest: s. 11. This practice continued until 1941 when the Act was amended giving the judge discretion to hold an inquest. [18]

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[18] Unfortunately, the *Debates of the House of Assembly* were not published during the war so this method of gaining some insight into the reasons for the policy change is not open to us.

4.4 Coroners abolished and *Fatality Inquiries Act* enacted: 1960-1963

This dual system of death investigation continued in Nova Scotia until the early 1960's when the *Coroners' Act* and the *Medical Examiner (Halifax and Dartmouth) Act* were both repealed and replaced by the *Fatality Inquiries Act,* S.N.S. 1960, c.6. One reason for repealing the *Coroners' Act* had to do with the "conduct of inquiries" as the proponent of the legislation stated on second reading:

> This is a procedure of a very long standing, something which has been done for a great many years, but which has not always been the easiest procedure to apply nor, when applied, not always the most satisfactory. It's questionable I think, sometimes as to how thou[ro]gh the inquiry conducted before a coroner's inquest may be, and perhaps also a matter of some question to how correctly related to the facts the results of that inquiry may be, and how the recommendations which come forward relates [sic] to the evidence which has been placed before the coroner and the coroner's jury.[19]

Another persistent problem was the inadequacy of the Act when it came to the remuneration of witnesses, jury members, and physicians conducting autopsies. The introduction of a province wide medical examiner system, similar to that found in Halifax and Dartmouth, was "in the interests of more successful and more searching and better conducted inquiries and in the interest of fairer treatment of those who become involved in inquiries". In future, inquiries would be based on the findings of medical examiners and "there may or may not be a magisterial enquiry held". The effect of the bill would be to eliminate coroners.[20]

The new legislation, entitled the *Fatality Inquiries Act,* provided for the appointment of a chief medical examiner in each county in the Province with inquests conducted at the discretion of provincial magistrates or at the direction of the Attorney General. The Province assumed "all the cost of all the fatality inquiries", relieving this "financial burden "from the municipalities.[21] The

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[19] Hon. Mr. Donahoe; *Debates of the Nova Scotia House of Assembly*, March 24, 1960, p. 1878-1879.

[20] Hon. Mr. Donahoe; *Debates of the Nova Scotia House of Assembly*, March 24, 1960, p. 1879-1880.

[21] It was estimated that the cost to the Province might amount to $20,000 year: *Debates of the House of Assembly*, March 24, 1960, p. 1883.

Act allowed for a coming into force on a county by county basis, and the continuance of the coroner system until proclamation.[22] On June 1, 1963, the Act, with housekeeping changes incorporated, was proclaimed province-wide. [23]

4.5 *Fatality Inquiries Act*: 1963 to the present

The Act was amended in 1975 to remove the dollar amounts to be paid office holders and physicians;[24] in 1977, to require medical examiners to report suspected child abuse;[25] and in 1982, to give the Attorney General extensive new powers including authority to order a post-mortem and direct an inquiry following an inquest. This amendment also introduced an option for magistrates to include recommendations in their inquest reports and authorized the extraction of the pituitary gland for use in the treatment of growth hormone deficiency.[26]

In 1984, the position of "Chief Medical Examiner for Nova Scotia" was introduced by amendment giving the office holder "general supervisory powers in respect to each chief medical examiner and each medical examiner for a county of the Province".[27] Explained Attorney General, Ron Giffin on the second reading:

> The intention of this Bill ... is to make specific provision for a Chief Medical Examiner for Nova Scotia, who has general supervisory powers ... over all other medical examiners and chief medical examiners appointed pursuant to the Act. Our reason for this ... is simply that ... the person has been functioning as Chief Medical Examiner for the Province of Nova Scotia is Dr. Roland Perry who, as you know, is the medical examiner in this area.

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[22] S.N.S. 1960, c. 6, s. 29-30. In the House, the Hon. Mr. Donahoe stated that "this act will not be put into force in any municipality which does not request it": *Debates of the House of Assembly*, March 24, 1960, p. 1881.

[23] *An Act to Amend Chapter 6 of the Acts of 1960, the Fatality Inquiries Act*, S.N.S. 1963, c. 46.

[24] S.N.S. 1975, c. 25 amending sections 23 [now s. 26] and 24 [now s.27] of R.S. 1967.

[25] S.N.S. 1977, c. 29., s. 1 amending Section 3 with addition of a subsection (4) [now s. 5(4)].

[26] S. N.S. 1982, c. 25, s. 1, amending subsection 4 by adding a new subsection (1A) [now s. 6(2)], and s. 2 amending s. 14 by adding subsections (3)-(5) [now s. 16(3)-(5)].

[27] S.N.S. 1984, c.21, s.1.

Even though a new office was being created, Mr. Giffin assured the House that a new position was not:

> First of all I do want to assure that honourable member that we're not creating a new job here per se, as a practical matter. As I understand it, Dr. Perry has been recognized as the chief medical examiner in the province for some time....
>
> I do want to point out ... that it's not suggested here that Dr. Perry would be exercising a day to day administrative function, rather he is a medical examiner. But in recognizing him as chief medical examiner, it is our view that it is appropriate that he have the power to set and enforce uniform standards and procedures across the province.[28]

In 1984, it would appear that the expectation of Government was that the administrative duties associated with the position of Chief Medical Examiner for the Province would be few, and that most of the time, the office holder would be actively engaged in investigating deaths.

A 1992 amendment resulted in the repeal of the former clause 16(1)(b) that permitted a presiding judge to make a finding of fact that would establish a *prima facie* case against a named individual sufficient to commit that individual to trial for a criminal offence.[29] The Department of Justice sought and received an order of the Supreme Court on December 17, 1991, declaring the section to be *ultra vires* on the basis that "it is criminal law which is within the exclusive jurisdiction of the federal criminal law power under s. 91(27) of the *Constitution Act, 1867*".

The 1992 amending legislation also limited the transcription of the hearings of an inquest to situations where it was required or requested under the *Court Reporters Act*.[30]

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[28] *House of Assembly Debates*, April 5, 1984, pp. 1155 -1159.

[29] This is John Pearson's summary in a letter to the Deputy Minister: see File 91-0011, memo dated June 11, 1991.

[30] The changes were incorporated in *An Act to Reform the Courts of the Province*, S.N.S. 1992, c.16, s. 17.

In 1995, the Act was amended to require that the Chief Medical Examiner for the Province hold a qualification as a pathologist. [31] The most recent change to the Act has been as a result of the *Court and Administrative Reform Act*, where provision is made for the Governor in Council to assign certain appointment powers under the *Fatality Inquiries Act* to a member of the Executive Council.[32]

5. INFRASTRUCTURE PROVIDED BY THE *FATALITIES INQUIRIES ACT*

There is no enunciated purpose clause in the *Fatality Inquiries Act* but, after the short title clause, it begins immediately with the appointment of office holders by the Governor in Council. This is followed by provisions respecting investigations into the medical cause of death by medical examiners: Sections 1-9. The second part of the Act, headed "Inquest by Judge", deals with the calling of inquests and procedures to be followed: Sections 10-18. The third part, entitled "General Provisions", includes a variety of Sections including the duty of police officers, the payment of various fees, and additional powers of medical examiners: Sections 19-31.

The is no reference in the Act to any administrative structure such as an office, bureau, division, or agency of medical examination. Neither is an "Office of the Chief Medical Examiner" mentioned in the statute.

5.1 Role of the Governor in Council

In addition to the powers to appoint office holders under Sections 2-4, the Governor in Council may impose duties upon the Chief Medical Examiner for Nova Scotia under subsection 2(7) and make regulations respecting the qualifications of this officer under subsection 31(1). In 1996, the *Court*

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[31] *An Act to Amend Chapter 164 of the Revised Statutes, 1989, the Fatality Inquiries Act*, S.N.S. 1994-95, c. 11, s. 1. A private member's bill, requiring that the office holder be "an expert in forensic pathology" had failed to make second reading when proposed on March 6, 1990: "An Act to Amend Chapter 164 of the Revised Statutes 1989, the *Fatality Inquiries Act*", Bill 23, 2d Session, 55th General Assembly, 1990; introduced by Dr. James Smith.

[32] *Court and Administrative Reform Act*, S.N.S. 1996, c. 23, s. 2(b).

and Administrative Reform Act, S.N.S. 1996, c. 23, s. 2(b) established a mechanism whereby a member of the Executive Council may be designated to appoint all office holders under the *Fatality Inquiries Act* with the exception of the Chief Medical Examiner for Nova Scotia. No such designation has been made to date.

5.1.1 Should a mandatory system of death investigation be established under provincial law?

One of the first issues to consider is whether the revised legislation should mandate the establishment of a death investigation system. At present, under the *Fatality Inquiries Act*, the appointment of any medical examiner, including the Chief Medical Examiner for Nova Scotia, is at the discretion of the Governor in Council. Nova Scotia is not alone in leaving it to the Executive to decide whether coroners or medical examiners will be appointed. In Manitoba, the Lieutenant Governor in Council "may appoint" medical examiners (s. 2(1)) just as coroners "may" be appointed in British Columbia, s. 1(1), 3(1), 4(1); Ontario, s. 3(1); and PEI, ss. 1(1), 2(1). On the other hand, in Quebec, the Government "shall appoint permanent coroners" (s. 5), and in Newfoundland, under s. 3(1), and Alberta, under s. 5(1), the Lieutenant Governor in Council is bound to appoint the Chief Medical Examiner. In Alberta, the appointment of other medical examiners is at the discretion of the Attorney General. In Newfoundland, the Chief Medical Examiner is responsible to the Minister for the appointment of medical examiners: s. 3(b).

In Nova Scotia, the Governor in Council is obligated to appoint an Auditor General, a Chief Electoral Officer, a chair of the Gaming Control Commission[33] plus a long list of appointment holders under more than 20 other provincial enactments. Is it an option for government to conduct itself without the services of medical examiners investigating "sudden" deaths?

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[33] *Auditor General Act*, s. 3(1); the *Elections Act*, s.4(1); the *Gaming Control Act*, 48(1).

5.1.2 Ought the revised legislation establish an "Office of the Chief Medical Examiner?"

It is commonplace to refer to the "Office of the Chief Medical Examiner". However, like the *Auditor General Act* which makes no reference to a board, office or agency of audit or an "Office of the Auditor General" (as opposed to the officer who is the auditor general) the *Fatality Inquiries Act* is silent respecting the establishment of an office of medical examination, or an Office of the Chief Medical Examiner. This contrasts with the "creation" or establishment under provincial statute of entities such as the Nova Scotia Boxing Authority,[34] the Nova Scotia Gaming Corporation,[35] the office of the Public Trustee, [36]the Nova Scotia Police Commission, [37] and the Labour Relations Board.[38]

From a reading of the legislation, no Canadian jurisdiction "establishes" a medical examiner's office or a coroner's office, though each statute appoints officers as medical examiners or coroners. It is practice in a number of American jurisdictions to establish offices. For example:

> There shall be an office of chief medical examiner, hereinafter called the office, under the supervision and control of the chief medical examiner ... which shall be within the office of public safety: Massachusetts, *Medical Examiners Act*: 38 M.G.L.A.C. §1B.
>
> The Commissioner shall establish and maintain, for medicolegal investigation of deaths and postmortem examinations, a central office and facilities in the City of Richmond and such district offices and facilities in such localities in the Commonwealth as are necessary: Virginia, *Postmortem Examinations and Services Act*, §132.1-277.
>
> There is hereby established in the department of health, the office of state medical examiners: Rhode Island, *Office of State Medical Examiners Act*, 23-4-2.

Under Nova Scotia legislation, it is the Attorney General and Minister of Justice who has

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[34] Established as a body corporate under s. 3(1) of the *Boxing Authority Act*.

[35] Established as a body corporate under s.8 of the *Gaming Control Act*.

[36] "Constituted" under s. 3(1) of the *Public Trustee Act*.

[37] Established under the *Police Act*, s. 4(1).

[38] Established under the *Labour Relations Act*, s. 16(1)

responsibility for the *Fatality Inquiries Act* and the office of the Chief Medical Examiner is part of the Department of Justice. The physical location of the office is on University Avenue in the Office of Clinical Research, part of the Victoria General site of the QEII Health Sciences complex.

In a number of American jurisdictions, medical examiners are not attached to the Attorney General's department. For example, in Virginia, the medical examiner's office appears, in legislation, as part of the Department of Heath and the act, entitled "Postmortem Examinations and Services"[39] includes a medical examiner section, an anatomical gifts section (similar to our *Human Tissue Gift Act*), a section headed "Use of Dead Human bodies for Scientific Study" (with provisions similar to our *Anatomy Act*), and a fourth section on "cremation". In Rhode Island, the Office of State Medical Examiners is established in the Department of Health, [40] while under the Connecticut *Medicolegal Investigations Act* the "Commission on Medicolegal Investigations is within the Department of Public Health and Addiction Services for administrative purposes only".[41] Several of these statutes require that the Office of the Chief Medical Examiner be physically located "at a medical school" in the state.[42]

In lieu of a chief medical examiner who reports to a member of the executive, some jurisdictions have established independent agencies with boards of directors overseeing the activities of medical examiners. Connecticut provides an example:

> §19a-401. (a) There is established a commission on medicolegal investigations, as an independent administrative commission, consisting of nine members: two full professors of pathology, two full professors of law, a member of the Connecticut Medical Society, a member of the Connecticut Bar Association, two members of the public, selected by the governor, and the commissioner of health services ..... The commission shall elect annually one of its members as chairman ... Members of the commission shall receive no compensation but shall be reimbursed for their actual expenses ... The commission shall meet at least once each year and oftener as its duties require ... The commission shall adopt its own rules for the conduct of its meetings.

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[39] Code of Virginia, c.8, §32.1-277 to 309.

[40] General Laws of Rhode Island, Title 23, c.4, 23-4-2.

[41] C.G.S.A. §19a, Public Health and Well-being, c. 368q, 19a-402.

[42] Connecticut, C.G.S.A. §19a-403; Massachusetts, M.G.L.A.C. 38§1B.

(b) The commission shall adopt regulations necessary or appropriate to carry out effectively the administrative provisions of this chapter.

§19a-403 The office of the chief medical examiner is established to be operated under the control and supervision of the commission. ... The office shall be directed by a chief medical examiner who shall be appointed by the commission....

Responsibility for the death investigation system is also invested in a Medical Examiners Commission in Florida though it is specifically stated to be created within the Department of Law Enforcement: §406.02.

Within Canada, we also have examples of boards or commissions overseeing the activities of coroners and medical examiners but their function appears to be quite different from the American examples just cited. In Ontario, a Coroners' Council is established under Section 6 of the legislation to monitor the conduct and performance of coroners and to recommend disciplinary action to the Minister where necessary: s. 7. The Fatality Review Board in Alberta has similar duties in addition to being responsible for making recommendations to the Minister respecting inquests.

5.2 Role of the Attorney General

Before taking up their duties, all medical examiners in Nova Scotia are required to take an oath of office and to file it with the Attorney General: ss. 2(5); 3(3)(b); 4(3)(c).

Along with the Governor in Council, the Attorney General has authority to impose duties or confer powers upon the Chief Medical Examiner for Nova Scotia: s. 2(7). Also where a vacancy occurs at the level of a chief medical examiner for a county, the Attorney General has authority to designate a medical examiner to take on the duties of chief medical examiner until an appointment is made: s. 4(4).

The Attorney General has authority to order a chief medical examiner to conduct an autopsy (post-mortem) where he or she considers it necessary and also to direct that there be further inquiry into the circumstances of an individual's death where "he thinks such an inquiry should be made": s. 6(2).

The Attorney General's powers at the inquest stage are equally significant: under Section 10 he or she has authority to order a judge of the Provincial Court to conduct an inquest even where a chief medical examiner has not recommended one; and, after the judge has conducted the inquest, the Attorney General may order that "a further inquiry be held, prescribe the terms of reference of the inquiry, determine when and to whom a report of the findings should be made and appoint a person to make the inquiry": s. 16(4). The person appointed to conduct this inquiry has the same powers as a commissioner appointed under the *Public Inquiries Act*: s. 16(5). The Act specifies that the Attorney General may appoint any counsel to act for the Crown at an inquest, including a prosecutor: s. 13(1). The Attorney General also has the power to give instructions with respect to the property of the deceased: s. 22.

5.3 Role of the Prosecutor for the County

The Act allows the Attorney General to appoint as counsel for the Crown "any prosecuting officer" or any other counsel under Section 13(1). In practice, prosecutors have always represented the Attorney General at inquests. The "prosecuting officer for the county" has authority to direct an inquest even where one has not been recommended by the chief medical examiner: s.10. From Section 11, it would appear that he or she can also direct a judge to hold an inquest whether or not the judge considers it necessary.

5.3.1 A continuing role for the Public Prosecutions Service?

In some jurisdictions, such as British Columbia and Ontario, a Crown Attorney acts as counsel to the coroner: *see* B.C., s. 27(1); Ontario: s.30. In New Brunswick, the coroner, "when he deems necessary, may request a crown prosecutor to attend and assist at any inquest": s. 22. In British Columbia, Ontario and Quebec the legislation provides for separate counsel for two different arms of the Province, the coroner and the Minister responsible for the act.[43]

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[43] In Ontario, the Crown Attorney acts as counsel to the coroner, and the Solicitor General (the Minister responsible for the Act) also "may be represented by counsel": s. 30(2). Similarly, under the British Columbia system: "The Attorney General may be represented at an inquest by counsel and is a person with standing at the inquest": s. 27(2) In Quebec, the Attorney General is represented by the "Attorney General's

In a decision of the Ontario Divisional Court dealing with procedural issues under the *Coroners Act*, the panel stated that at every inquest "the primary advocate for the overall public interest is the crown who acts as counsel for the coroner": *People First of Ontario* v. *Porter, Regional Coroner Niagara* (1992), 5 O.R. (3d) 609 at 620. The court acknowledged that someone who had been prosecuted by the Crown "might not have full confidence in the advocacy provided by their former adversary" but on the facts in *People First*, this issue did not arise.

Is it in this role as advocate of the public interest that the prosecutor is properly seen under the *Fatality Inquiries Act*? In a system where a judge conducts the inquest, there is no need to have counsel assigned to assist with legal and procedural matters as may well be the case in British Columbia or New Brunswick where the coroners are lay persons. However, in a hearing which has no "parties" in the usual sense, the responsibility for drawing out the testimony of witnesses and gathering relevant evidence remains and as one commentator has written, "It is difficult for a person to assess evidence objectively if he has to himself elicit the facts".[44]

As written, there is no requirement in the Nova Scotia Act that a Crown Attorney attend the inquest for the Attorney General may appoint other counsel to represent him under Section 13(1). In their 1994 report on the Public Prosecution Service, Bruce Archibald and Joe Ghiz were of the opinion that the *Fatality Inquiries Act* ought to be amended so that the Director of Public Prosecutions would "discharge the functions of the Attorney General in fatality inquiries". Additional amendments would remove references to "prosecuting officers" and substitute "a reference to the Director of Public Prosecutions or a Crown Attorney under his or her direction as the person authorized to represent the Attorney General in Fatality Inquiries."[45] Whether these are also the views of the

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prosecutor or the advocate representing the Attorney General" (referenced in ss. 150-153) while "an attorney designated by the Chief Coroner" assists the coroner if he so desires (s. 109).

[44] L.A. Hallett, *Royal Commissions and Boards of Inquiry: Some Legal and Procedural Aspects* (Sydney: Law Book Co., 1982) at 216-217; cited by John Sopinka, "The Role of Commission Counsel," in *Commissions of Inquiry*, edited by A. Paul Pross, Innis Christie, John Yogis. (Toronto: Carwell, 1990) at p.77.

[45] Joseph A. Ghiz and Bruce P. Archibald, *Independence, Accountability and Management in the Nova Scotia Public Prosecution Service: A review and evaluation.* Submitted to the Minister of Justice for the Province of Nova Scotia on August 31, 1994, Recommendation 34(b), at p. 150. Were this to be done, there would also be a

Public Prosecution Service will be learned in consultation. Some consideration may well need to be given to the role of the Public Prosecution Service in a procedure that no longer has a criminal law focus.

5.4 Role of the Auditor General

The Act specifies that the Auditor General may have access to all reports of the chief medical examiner filed with the clerk of the Crown: s. 30. Is there a purpose in continuing with this position?

5.5 Role of the Police

The Act directs every police officer to notify the chief medical examiner of deaths requiring examination by him or her and also to give the chief medical examiner "all police assistance that he requires in the discharge of his duties and generally aid and assist him in the performance of his duties under this Act": s. 23.

In Ontario, the statute requires that police forces make "available to the coroner the assistance of such police officers as are necessary for the purpose of carrying out the coroner's duties': s. 9(1). When the coroner needs it, he or she may also request the assistance of the criminal investigation branch of the Ontario Provincial Police under s. 9(2).

Under the Nova Scotia Act, the RCMP[46] has a specific responsibility to deliver that property of the deceased gathered by the chief medical examiner "on or near the body" to the "person or persons entitled to its custody or possession": s. 22. Alternatively, the Attorney General may establish "instructions" for dealing with these items.

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consequential amendment to the *Public Prosecutions Act*: Recommendation 34(a) at p. 149.

[46]Note that the municipal police forces are not referred to here.

5.5.1 What is the relationship between medical examiners and the Police?

While only the medical examiner is directed by statute to investigate a suspicious death, it is accepted that the police have the responsibility for directing a criminal investigation. The interrelationship between the police and medical examiners is explained in Alberta as follows: when a criminal matter is suspected, the police take charge of the investigation, and the medical examiner assists the police. However, when it is clearly a medical examiner case, the medical examiner takes charge and the police assist the medical examiner. [47] In either instance, the medical examiner is always neutral in his or her approach to the case.

Under the Manitoba legislation, there is an express duty for the medical examiner to inform the police when he or she "learns of a death" covered by the act.

As noted earlier, only slightly in excess of two percent of the cases investigated by medical examiners involve foul play, and about 38 percent involve accidents or suicides. In more than 60 per cent of the cases seen by medical examiners, the individual has died of natural causes.

From an operations perspective, the police and the medical examiner need to work together. The police have the capacity to respond quickly to a death and the 911 communications system reflects this fact. The purpose of the 911 legislation is "to establish the number "911" as the primary emergency telephone number for use in the Province and to implement a province-wide system for the reporting of emergencies to emergency service agencies": *Emergency "911" Act*, s.2. Included in the definition of "emergency services agencies" are: "all municipal police forces required to be maintained pursuant to the *Police Act*, including the Royal Canadian Mounted Police": s. 3(b). Generally, the medical examiner will be the third party to the scene of a death, and only after he or she has been informed by the police that he is needed. Note that neither in the 911 legislation or in any other statute is anyone, including the police or the medical examiner, mandated by law to attend the scene of every sudden or unexpected death.

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[47] Alberta. Department of the Attorney General. Office of the Medical Examiner, *Investigations of Sudden Death: A Medical Examiner's Guide*. (Edmonton: the Office, 1987) at p. 40.

While there is active liaison between the Chief Medical Examiner's office and various policing offices, Dr. Butt is of the view that in some policing areas there is a lack of confidence in the existing medical examiner system. A satisfactory system would be one where medical examiners and police worked cooperatively and where their respective areas of expertise were recognized.

The roles of the police and the medical examiner could be clarified in revised legislation. For example, in Alberta, the following provision is included:

> 32 If, at any time during the course of his investigation, a medical examiner is of the opinion that an offence under the *Criminal Code* (Canada) that is related to the death being investigated may have been committed, he shall immediately notify the Chief Medical Examiner and the Chief Constable or officer in charge of the nearest police detachment or station.

5.6 Role of the Chief Medical Examiner for Nova Scotia

The Province is served by a Chief Medical Examiner for Nova Scotia who is appointed by the Governor in Council and holds office during pleasure: s. 2(1); s. 2(3). The appointment is at the discretion of government -- *may* appoint -- and the office has been in existence only since 1984. The current office holder is Dr. John Butt. [Since this paper was written Dr. Butt has left the office and been replaced by interim Chief Medical Examiner, Dr. Vernon F. Bowes.]

The Chief Medical Examiner for Nova Scotia must be: (1) "a duly qualified medical practitioner who has special training in pathology", (2) "registrable in the Medical Register of the Province of Nova Scotia as a pathologist", and (3) meet "any other additional requirements prescribed by the regulations": s. 2(2). The requirement that the chief medical examiner be a pathologist became effective on May 1, 1995.[48] At the same time, a new, and highly particularized Section 31 was added to the *Fatality Inquiries Act* authorizing the Governor in Council to make regulations in respect of subsection 2(2).[49] To date, no regulations have been made under this Section.

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[48] *An Act to Amend Chapter 164 of the Revised Statutes, 1989, the Fatality Inquiries Act*, S.N.S. 1994-95, c. 11, s. 1.

[49] S.N.S. 1994-95, c. 11, s. 2

The Chief Medical Examiner for Nova Scotia has supervisory powers over all other medical examiners in the Province: s. 2(6). Under subsection 2(7), he also has those duties and powers that are conferred or imposed on him by the Governor in Council or the Attorney-General. To date, no orders in council assigning duties to the Chief Medical Examiner for Nova Scotia have been issued. However, the Attorney General has assigned responsibilities to the current Chief Medical Examiner under his contract of employment which include:

a) providing consultation and advice to medical practitioners, pathologists, police, Crown Attorneys and lawyers;

b) directing investigations and handling complex cases which require expertise in forensic pathology;

c) performing autopsies;

d) presenting expert evidence as required at inquests or in court; and

e) performing all related administrative responsibilities affiliated with the Office of the Medical Examiner.

With the exception of subsections 2(6)-(7) of the Act, there is no further reference in the statute to duties of the "Chief Medical Examiner for Nova Scotia", although there are many references to the duties of a "chief medical examiner" who is appointed for a particular county.

There is no provision for a person to act in the absence of the Chief Medical Examiner for the Province.

5.6.1 To what degree is the Chief Medical Examiner "independent" of government?

In the opening paragraphs of the *Canadian Law of Inquests*[50], Justice David Marshall laments the decline in the independence of coroners and medical examiners:

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[50] Marshall, at p. 1.

> The institution of the coroner remains a complex interplay or balancing of public and private rights; perhaps the most worrisome change to the citizen is the increasing loss of the independence of the office of the coroner or medical examiner. Although it seems undesirable, both the statutes and practice are eroding coronal independence. Only if the investigation is free from pressure – governmental or other – can the coroner or examiner act freely to expose fully the realities of suspicious deaths in our midst. The increasing proximity of government in controlling the investigation may be seen as one of the unfortunate side effects of the more complex institution we now have, in contrast to the common law coroner acting with almost total independence from government.

The Ontario Law Reform Commission, in its 1995 review of the death investigation legislation in that province, recommended that "all coroners should be, and should be perceived to be, independent of local institutions".[51] The Saskatchewan Law Reform Commission proposed in 1984 that one of the purposes of revised coroners' legislation would be to "provide for independent, impartial investigation into circumstances surrounding deaths".[52] The Commissioners appear to be referring to the judicial function of coroners during inquests as well as their responsibilities at the pre-inquest stage.

What are we to understand by the word "independent"? In the context of the judicial function, the word has been held to mean "freedom from interference by the Executive or Legislature in the exercise of the judicial function".[53] And in the context of the pre-inquest death investigation phase, how is "independent" to be interpreted? The Chief Medical Examiner for Nova Scotia needs to be independent of political interference in the conduct of his work, but because all legal authority is traced back to the legislative body, the Chief Medical Examiner for Nova Scotia must be accountable to either a member of the executive (e.g. the Attorney General) or the House itself. An important distinction may be added here: the Chief Medical Examiner for Nova Scotia acts under

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[51] Ontario Law Reform Commission, *Report on the Law of Coroners*. (Toronto: the Commission, 1995) at p. 191.

[52] Saskatchewan Law Reform Commission. *Proposals for a new Coroners Act*. (Saskatoon: The Commission, 1984) at p.39, s. 3(g).

[53] On this point, LeDain, J. cites Fawcett, *Application of the European Convention on Human Rights* (1969) and Shetreet, *Judges on Trial: A Study of the Appointment and Accountability of the English Judiciary* (1976). Peter W. Hogg observes that unlike the U.S. and Australia, Canada "retained the British system of responsible government. The close link between the executive and legislative branches which is entailed by the British system is utterly inconsistent with any separation of the executive and legislative functions": *Constitutional History of Canada*. (Toronto: Carswell, 1992-) at p. 14-5 [loose-leaf ed.].

statutory authority, *not* under the authority of the Attorney General. He is accountable to the Attorney General for the performance of his duties, but *not* for his opinions on the cause and manner of death.

Appendix A, Table B compares the relative autonomy of a number of provincial office holders in light of factors identified by LeDain, J. as promoting judicial independence in *R.* v. *Valente (No. 2)*. LeDain, J. saw a correlation between freedom from the interference of the executive or the legislature, and a provincial court judge's (a) security of tenure, (b) security of salary and pension, and (c) institutional independence "with respect to matters respecting administrative matters bearing directly on the judicial function". Each office holder, working under a provincial statute, is accountable to a member of the executive or the legislature, but some clearly function at a greater distance from the immediate involvement of the legislature or executive in the day to day running of the affairs of the office.

5.6.2 Are the qualifications of the Chief Medical Examiner and the responsibilities and powers of the Chief Medical Examiner adequately expressed in statute?

Since the *Fatality Inquiries Act* was amended in 1995, it has been a requirement that the Chief Medical Examiner for Nova Scotia have "special training in pathology" and be registrable as a "pathologist". The Act permits the Governor in Council to add other requirements by regulation but none have ever been made. Alberta also requires that the chief medical examiner be a pathologist.[54] The Newfoundland legislation states that he or she must be "a pathologist with training or experience in forensic pathology"[55] Whether the Nova Scotia legislation should specify forensic pathology experience is an issue to consider. Scaling back the qualifications demanded for the position of Chief Medical Examiner for Nova Scotia, however, would likely undermine public confidence in the system.

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[54] *Fatality Inquiries Act*, R.S.A. 1980, c. F-6, s. 5(1)

[55] *Fatalities Investigations Act*, S.N. 1995, c. F-6.1, s. 3(1).

The *Fatality Inquiries Act* provides only the barest sketch of the actual responsibilities of a Chief Medical Examiner(CME) and is ambiguous as to whether the CME actually takes on the duties of medical examiners. The use of upper case letters to distinguish one position from another is troublesome, particularly in this Act where so much is placed on the county level chief medical examiner. All the duties of the "hands on" medical examiner's work are assigned to the "chief medical examiner for each county of the Province" or someone acting in his place under the terms of subsection 4(1). Can we assume that the duties and powers of the county chief medical examiners are also those of the Chief Medical Examiner for Nova Scotia? In practice, the Chief Medical Examiner for Nova Scotia offers guidance to medical examiners, and administers the non-inquest portions of the Act. In addition, he exercises those duties and powers assigned to chief medical examiners for particular counties.

Under the Newfoundland act, this matter is dealt with squarely under subsection 3(2) where it states the Chief Medical Examiner may also "exercise and perform the powers and duties of a medical examiner". A clause expressing a like idea was proposed by the Saskatchewan Law Reform Commission, at s. 5 which reads: "The Chief Coroner has all the rights and powers of a coroner".[56]

What may be an additional duty of the Chief Medical Examiner for Nova Scotia is inferred from s. 4 B (e) of the *Civil Emergency Planning Regulations* (N.S. Reg. 82/71) made under the *Emergency Measures Act*, S.N.S. 1990, c.8, which states that in the event of "both major peacetime disaster and war emergency" the Department of Justice and Attorney General shall "provide the services of the Supervising Coroner to the Department of Health for the development and operation of an Emergency Mortuary Plan". The wording of this regulation will need to be up-dated as Nova Scotia no longer has coroners and there is no position in statute known as "Supervising Coroner".

In several Canadian jurisdictions, the duties or responsibilities of the Chief Medical Examiner have been set out in statute in considerable detail. Depending on the jurisdiction, a non-exhaustive list of responsibilities includes: administering the statute, appointing medical examiners and medical

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[56] Saskatchewan Law Reform Commission. *Proposals for a new Coroners Act.* (Saskatoon: the Commission, 1984), at p.40.

investigators, appointing an Acting Chief Medical Examiner, assisting medical examiners in obtaining medical and other experts where necessary, authorizing autopsies, educating persons with responsibilities under the legislation, developing and maintaining facilities, preparing and distributing a code of ethics, and ordering disinterments. A summary of these duties, drawing from the Alberta, Newfoundland, and Ontario statutes and the 1984 recommendations of the Saskatchewan Law Reform Commission is found in Appendix A, Table C. Note that the duties respecting the conduct of inquests (where applicable) are not included.

5.7 A Chief Medical Examiner for a County

The Act authorizes the Governor in Council to appoint a *chief medical examiner for each county* in the Province: s. 3(1) [emphasis added]. Each person appointed must be a "duly qualified medical practitioner" and holds office during pleasure: s. 3(2); s. 30(3)(a).

These appointments are at the discretion of Cabinet and in fact, *no* person has been appointed as a chief medical examiner for a county in the past dozen years. Prior to the introduction of legislation creating the office of Chief Medical Examiner for Nova Scotia, it was practice to have the "chief medical officer of a county" -- a functionary of the Department of Health -- assume the position of the "chief medical examiner for a county".[57] Remnants of this earlier practice may remain in the Act in the headings preceding Sections 15 and 26 which both refer to the " the chief medical officer".

Subsections 4(5)-(6), which confirm the appointment of a "medical examiner for a county" or a deputy medical examiner appointed prior to June 1, 1963[58] as "a chief medical examiner for the

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[57] Personal communication with Ms. Linda Mosher, office of Chief Medical Examiner for the Province, May 6, 1998. Mr. Wayne Cochrane, former Senior Solicitor for the Department of Health, advised that currently there are only three medical officers appointed in the province.

[58] The date when the former *Medical Examiners (Halifax and Dartmouth) Act* was repealed.

county" are spent. If practice has shown that this position is no longer required, or that there is a better organizational structure, clearly the references to a "chief medical examiner for a county" must be removed from the Act.

5.8 Medical Examiners

The legislation authorizes a chief medical examiner of a county to appoint, with the approval of the Governor in Council, medical examiners to act when he or she is unable to act: s. 4(1). However, as no one is currently appointed as a " chief medical examiner" for a particular county, the subsection 4(1) method of appointment has been superseded by a practice whereby an "appointment" is made by the Chief Medical Examiner for Nova Scotia, and recommended for the approval of the Governor in Council. On the report and recommendation of the Minister of Justice, the appointment of the Chief Medical Examiner is approved by the Governor in Council and published in an order in council. The medical examiner is appointed as *a* medical examiner in a particular county.[59]

In Alberta, the appointment of medical examiners, other than the Chief Medical Examiner, is at the discretion of the Attorney General. In Newfoundland, the Chief Medical Examiner is responsible to the Minister for the appointment of medical examiners under s. 3(b).

The *Fatality Inquiries Act* requires a medical examiner to be a "duly qualified medical practitioner"[60]: s. 4(2). The medical examiner has all the powers conferred by the Act on chief medical examiners "when acting in the place of the chief medical examiner" : s. 4(3). Medical examiners are supervised by the Chief Medical Examiner for Nova Scotia (s. 2(6)) and currently 80 persons work as medical examiners under the supervision of Dr. John Butt.

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[59] As noted earlier, the *Court and Administrative Reform Act*, s. 2(b) provides a mechanism for designation of a member of the Executive Council to approve appointments under the *Fatality Inquiries Act*, with the exception of the position of Chief Medical Examiner for Nova Scotia.

[60] This phrase is defined under the *Interpretation Act*, s. 7(1)(d): "duly qualified medical practitioner", "legally qualified medical practitioner" or any other words or expressions importing legal recognition of a person as a medical practitioner or member of the medical profession means a person registered under the *Medical Act*.

The Act sets out the powers and responsibilities of the county chief medical examiners -- for which we will read here "medical examiners" -- to be these in respect of the medical cause of death: taking charge of the body; investigating the death; entering premises where a dead body is believed to be and removing it; taking charge of any money or other personal property of the deceased found on or near him; delivering the personal effects to the RCMP; performing autopsies or engaging another medical practitioner to do the autopsy; authorizing the extraction of the pituitary gland; engaging the services of experts where needed; releasing the body; preparing a report setting out the results of the investigation respecting the cause and manner of death; and filing this report with the Clerk of the Crown. Where child abuse is suspected, this must be reported to the Child Abuse Register. Medical examiners also have responsibility to notify a provincial court judge of particular categories of deaths that may need to be considered for an inquest. This is discussed further under § 9.1

Under related legislation, the medical examiner directs that tissue be removed from the deceased for transplant under appropriate circumstances (*Human Tissue Gift Act*, s. 7); reports to the Inspector of Anatomy respecting unclaimed or unidentified bodies, or where there is a deceased who requires burial or cremation at public expense (*Anatomy Act*, s. 5(1); s. 5(3); s.14); and completes a medical certificate of death in accordance with the *Vital Statistics Act*, s. 12 and ss. 17(4)-(5). Under s. 98(8) of the *Motor Vehicle Act* medical examiners are to report to the Registrar of Motor Vehicles respecting motor vehicle related deaths under the *Motor Vehicle Act*. In practice, the office of the Chief Medical Examiner advises that medical examiners do not generally file a report with the Registrar of Motor Vehicles but rely on the report filed by the police under s. 98(4).

5.8.1 Is a "duly qualified medical practitioner" a sufficient qualification to carry out the responsibilities of a medical examiner?

In Nova Scotia, medical examiners are typically general practitioners, and it has been said that the attractions of medical examiner service are limited for the fees for service are low ($80 per case) and the hours irregular. Many medical examiners estimate that they spend two to three hours responding to a typical sudden death call, and often it is awkward to leave their practices when notified of a

death. A decade ago, the Joint Committee of the Nova Scotia Medical Society and the Nova Scotia Barristers' Society said that "medical examiners are not well paid for their services, and it is recommended that the fees paid to medical examiners be reviewed and revised".[61]

A number of years ago, some medical examiners expressed the view that they lacked the necessary training to do their jobs properly and looked to the office of the Chief Medical Examiner to provide in-service training. This issue was the focus of comment in a 1990 inquest where the judge stated that, while in his view the facts did not disclose evidence of an unlawful act or culpable negligence, the "circumstances of the death ... cried out for a prompt autopsy followed by a Fatal Inquiry under the *Fatality Inquiries Act*." The failure of the medical examiner to order an autopsy and inquest[62] "constituted a serious error" on the part of the medical examiner and reflected the physician's limited understanding of his responsibilities under the Act. However, "in fairness to Dr. ... the Inquiry accepts his evidence that his appointment as medical examiner was a very casual affair, far too casual for the heavy responsibility that evolves on medical examiners from time to time and further than he received little or no instruction or training or information concerning the office of medical examiner other than some printed copies of the *Fatality Inquiries Act* despite his requests and sincere desire to obtain same". [63]

The insufficiency of direction of medical examiners was also commented on by the Registrar of the Provincial Medical Board who wrote the Deputy Minister of Justice in 1992 respecting a discipline hearing where a medical examiner was interviewed. The medical examiner (who was not the subject of the discipline hearing) stated in the interview that he had never received instructions respecting his duties or obligations and had never seen a copy of the *Fatality Inquiries Act*.[64]

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[61]Joint Committee of the Medical Society of Nova Scotia and the Nova Scotia Barristers' Society. Report of the Joint Committee of the Medical Society and Barristers' Society regarding the *Fatality Inquiries Act* of Nova Scotia. (Halifax: the Committee, 1988) at p. 5.

[62]The medical examiner has no authority to order an inquest, only to forward a copy of his report to the Provincial Court.

[63]In the Matter of the *Fatality Inquiries Act* and in the Matter of the Death of Jason Roast; His. Hon. Judge P. R. Woolaver, May 17, 18, June 18, 19, 1990 at pp. 49-50.

[64]B. J. Steele to D. W. MacDonald, July 21, 1992/92-0022-01.

Chief Medical Examiners in Alberta, s. 5(4)(d) and Newfoundland s. 3(4)(f) have a responsibility to "educate persons required to perform functions under the Act". The Ontario statute requires the Chief Coroner to conduct "programs for the instruction of coroners in their duties (s. 4(1)(c)). Ought medical examiners be required to take in-service training, and should the responsibility for such training be added to the list of the Chief Medical Examiner's responsibilities?

5.8.2 Are the responsibilities and powers of medical examiners adequately described in statute?

Looking at the Act itself, it is seen that the responsibilities of medical examiners are numerous, and comparable to those of similar office holders in other jurisdictions. Appendix A, Table D compares the duties of medical examiners in Nova Scotia with their counterparts in Alberta, Ontario, and Newfoundland as set out in the statutes.

While some of these jurisdictions provide greater detail in statute, for the most part, this comparison of legislation shows that enactments provide for much the same things in the pre-inquest phase: (1) the jurisdiction of the medical examiner or coroner; (2) the responsibilities and powers needed in investigating a death; (3) the duties respecting the release of the body when the investigation is completed; (4) the preparation of certain reports; and (5) the medical examiner's or coroner's role in the calling of inquests. In addition, there are a number of prohibitions, listed in Appendix A, Table E, which are further indicators of the scope of the medical examiner's authority.

Over a decade ago, in 1988, a Joint Committee of the Medical Society of Nova Scotia and the Nova Scotia Barristers' Society expressed the opinion that the duties and powers of medical examiners as set out in the Act were insufficient as a guide to medical examiners in carrying out their duties. The Committee stated that "there is virtually no direction in the *Fatality Inquiries Act* regarding the procedures which medical examiners should follow in conducting investigations". In other jurisdictions, the Committee continued, medical examiner manuals had been developed which

"contain comprehensive guidelines regarding the nature and scope of the duties of medical examiners .... they [the guidelines] can also serve to put in place uniform procedures throughout the Province".[65]

What the Joint Committee appears to have identified was a weakness ten years ago in the preparation and training of general practitioners to carry out the particulars of the medical examiner's role, rather than a lack of specifics in the Act respecting the medical examiner's duties. It would be unusual for a statute to incorporate the sort of detail a set of guidelines might encompass,[66] but making it a requirement that medical examiners undertake upgrading or continuing education in the area of death investigation would not.

5.8.3 Are there persons other than physicians who can assume some of the duties of medical examiners? Ought a revised statute provide for "investigators?

Under optimum conditions, medical examiners or coroners who are physicians go to each scene of death, see the body, and conduct an investigation. Dr. Butt advises that this is the practice in Ontario. However, in some jurisdictions, because of the cost associated with having physician undertake all the duties of medical examiners, persons who are not physicians are appointed as medical *investigators*. These individuals, working under the supervision of a medical examiner, usually have a health science background, e.g nurses, pharmacists. The U.S. based Network on Death Investigation Affairs describes "death investigators" as those people who "obtain and document information on reported deaths, conduct scene investigations, and participate in other aspects of death investigations as directed by, or in conjunction with the medical examiner or

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[65] Joint Committee at pp. 4-5.

[66] Currently, the *Investigations of Sudden Death: A Medical Examiner's Guide* prepared by the Alberta Office of the Medical Examiner is available in Nova Scotia as a resource for medical examiners.

coroner".[67] Investigators are provided with specialized training (either in-house or elsewhere)[68] and are able to assume numbers of the functions of the medical examiner and determine a significant proportion of the causes of sudden or unexpected deaths.

In Nova Scotia, a pilot project is underway in the Annapolis Valley where nurse investigators are assisting medical examiners. Within Halifax-Dartmouth (not county-wide), nurse investigators have been assisting the chief medical examiner's office.

In Alberta and Newfoundland, the legislation allows for the appointment of investigators to work with medical examiners. For example, under the Newfoundland statute

2 (d) "investigator" means a medical examiner's investigator who acts as an assistant to the medical examiner in determining the manner and cause of death and who is appointed under section 3 or a person who is a medical examiner's investigator under section 10 of this Act;

3 (4) The Chief Medical Examiner is responsible to the minister for

(c) the appointment of medical investigators.

10 [Duties of medical examiner]

11 (1) An investigator, when authorized by a medical examiner,

(a) shall assist the medical examiner in carrying out his or her duties under this Act; and

(b) may exercise the powers and duties of a medical examiner as enumerated in section 10.

(2) Every member of the Royal Newfoundland Constabulary and the Royal Canadian Mounted Police is by virtue of his or her office, a medical examiner's investigator.

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[67] NODIA [Network on Death Investigation Affairs] Courses for Death Investigators, at http://www.thename.org/NODIA/NODIACdi.htm.

[68] For example, in the United States, five day basic and advanced courses for medicolegal death investigators are offered by the St. Louis University Health Science Centre in St. Louis, Mo. The Office of Medical Investigator at the University of New Mexico in Albuquerque offers a four day course.

Dr. Butt advises that dealing with the presence of death on a regular basis and also interacting directly with the deceased's family at the scene of death are essential elements of death investigation which require preparation and education. In this part of the world, even police officers with five to ten years experience will often have seen but a handful of suspicious deaths and if they were to act as death investigators, they too would likely need additional training in this area.

6. CLASSES OF DEATHS TO BE REPORTED

Subsection 5(1) of the *Fatality Inquiries Act* requires that four particular categories of deaths be reported to a medical examiner:

(1) where there is a "reasonable cause to suspect that the person died by violence, undue means or culpable negligence";

The phrase "undue means" in the context of someone's death, has not been judicially defined, but in general, it means "wrong" or "improper". [69]

(2) where "the person died in a place or under circumstances requiring an inquest under any statute";

There are no mandatory inquests in Nova Scotia under the *Fatality Inquiries Act*. Neither are there any other provincial statutes which establish a requirement for an inquest. However, the *Coal Mines Regulations Act*, s. 67, specifically excludes the *Fatality Inquiries Act* where "any accident occurs in any mine from any cause resulting in the loss of life", and under similar circumstances, the *Metalliferous Mines and Quarries Regulations Act*, s. 9 states that "no medical examiner of the county in which the accident occurs shall hold an inquest touching the death of such person". (Medical examiners, of course, do not conduct inquests.) These two acts provide alternative

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[69] *Black's Law Dictionary* provides a definition that reads in part:: " 'Undue'. -- More than necessary; not proper; illegal. It denotes something wrong, according to the standard of morals which the law enforces in the relations of men, and in fact illegal . . . "

methods of investigating deaths in mines; both have been repealed under the *Occupational Health and Safety Act*, but the relevant sections of that Act have not yet been proclaimed so they remain in force.[70]

There are no federal statutes that mandate inquests, although the *Canada-Nova Scotia Offshore Petroleum Resources Accord Implementation (N.S.) Act* provides for an inquiry into a death "offshore" at the discretion of the Board established under that act: s. 162.

(3) where "the cause of death is undetermined"; and

(4) where "the person died in jail or prison".

In practice, another category of death -- where there is no attending physician available to sign the medical certificate of death -- is, in fact, reported to medical examiners by virtue of subsections 12(3) and 17(3) of the *Vital Statistics Act*. This is discussed further under §10.1.3, *Attending Physician*.

A comparison of legislation (see Appendix A, Tables F - J) shows that the reportable deaths in Canadian jurisdictions fall into at least one of the following broad categories: (1) sudden, violent, or unexpected deaths; (2) deaths related to medical procedures, or lack of medical procedures or care; (3) deaths in institutions where residents are either "vulnerable" because of their age, state of health, or mental capacity, or where they are held against their will; (4) workplace related deaths; and (5) deaths of children under particular circumstances. Dr. Butt advises that the sorts of deaths most frequently reported to medical examiners in Nova Scotia are those which can be described as "sudden" or "unexpected".

The language of the present Act needs modernizing when it comes to the issue of reportable deaths. A policy decision would be whether rephrased broad categories should replace the existing categories, or whether more detailed listings of circumstances which are to reported to the medical

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[70] *Occupational Health and Safety Act*, ss. 86, 87, 89(4).

examiner would be preferable, or whether the status quo should continue. Some examples of the latter style of legislative drafting are cited with the comments which follow.

6.1 Deaths in health care facilities

In 1994 and 1995 more than 64 per cent of Nova Scotians died in hospital. Another small percentage died in nursing home type residences.[71] In the Newfoundland statute the following wording was selected to deal with deaths in health care facilities:

> 6 (1) Where a person dies while in a health care facility, or another place where patients are received for treatment or care and there is reason to believe that
>
> (a) the death occurred as the result of violence, attempted suicide or accident, no matter how long the patient had been hospitalized;
>
> (b) the death occurred as a result of suspected misadventure, negligence or accident on the part of the attending physician or staff;
>
> (c) the cause of death is undetermined;
>
> (d) the death occurred during or following pregnancy in circumstances that might reasonably be related to pregnancy;
>
> (e) a stillbirth or neonatal death has occurred where maternal injury has occurred or is suspected, either prior to admission or during delivery; or
>
> (f) the death occurred within 10 days of an operative procedure or the patient is under initial induction, under anaesthesia or during the recovery from anaesthesia,
>
> the person responsible for that facility shall immediately notify a medical examiner or an investigator.
>
> (2) Where a person is declared dead on arrival or dies in the emergency department of a health care facility as a result of a condition referred to in section 5, the person responsible for that facility shall immediately notify a medical examiner or an investigator.

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[71] Nova Scotia. Department of Business and Consumer Affairs. Vital Statistics. *Annual Reports 1994, 1995*, Table V.

6.2 Deaths in correctional institutions

Nova Scotia requires that deaths in jails or prisons be reported to medical examiners by the superintendent of the institution. The Newfoundland legislation goes further and provides that:

> 7. Where a person dies
>
> (a) while detained in a correctional institution, such as a jail, penitentiary, guard room, remand centre, detention centre, youth facility, lock-up or any other place where a person is in custody;
>
> (b) while an inmate or patient in treatment facilities or parts, or psychiatric divisions of treatment facilities or parts, or classes of treatment facilities designated under the *Mental Health Act*;
>
> (c) while in the custody of the Director of Child Welfare; or
>
> (d) while in the custody of a peace officer, the person in charge of that institution or the person having the custody of that person shall immediately notify a medical examiner or an investigator.

The Alberta legislation is similar and includes a provision that the death is reportable even where the prisoner is not in custody: s. 12.

6.3 Deaths of children

Reports of deaths of children from abuse or neglect and the failure of social agencies to identify those at risk have been the focus of concern in many provinces in recent years. In Nova Scotia, a Preventable Child Death Review Committee, a multi-disciplinary team comprising members from the departments of Community Services, Justice, and Heath and from the IWK Grace Hospital, meets to consider child deaths on a regular basis.

Where a child has died in care, Alberta legislation requires that "A director under the *Child Welfare Act* shall immediately notify a medical examiner of the death of any child under his guardianship or in his custody": s. 13. The Newfoundland provision, s. 7(c), is similar. The Nova Scotia Act requires a reporting of death due to suspected child abuse: s. 5(4). In the view of one writer,

> Notification that a child has died unexpectedly triggers, or should trigger, investigations by the medical examiner, law enforcement and child protective services. .... The medical examiner determines the cause of death and, with law enforcement, determines the circumstances surrounding the death. Child protective services determines the safety of the other children ... When a child's death is the result of mistreatment, the safety of surviving children depends on the effectiveness of these investigations. [72]

6.4 Workplace deaths

For the period, 1991-1995, occupational deaths in Nova Scotia were reported as:

Table 2
Occupation related Deaths: Nova Scotia, 1991-1995

1991	28	8.16
1992[73]	47	14.03
1993	18	5.52
1994	7	2.07
1995	17	4.97

Source: Human Resources Development Canada. Labour Branch. Research and Analysis Section ... *Occupational Injuries and their cost in Canada, 1991-1995*. (Ottawa: the Section, 1996) Table 1, at p. 12.;Table 2, at p. 14.

A report of Human Resources Development Canada states that "one worker out of 16,715 died from an occupational injury" in 1995 in Canada.[74] In Nova Scotia, the report shows that the rate of fatalities in the workplace has declined sharply from 13.1 per 100,000 in 1971 to 6.0 per 100,000 in 1995.

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[72] Sarah R. Kaplan, "An Introduction to Child Fatality Review Teams," (1992) 13 *Children's Legal Rights Journal* 8 at p.10.

[73] This was the year of the Westray Mining disaster and under the *Coal Mines Regulation Act*, the medical examiner would have been excluded from conducting an investigation into the deaths. Another method of inquiry is provided under that statute.

[74] Human Resources Development Canada. Labour Branch. Research and Analysis Section ... *Occupational Injuries and their cost in Canada, 1991-1995*. (Ottawa: the Section, 1996), at p.11.

Under the Nova Scotia *Occupational Health and Safety Act*, an employer must report a workplace death within 24 hours to the Executive Director of Occupational Health and Safety: s. 63(1)(c). No one is to disturb the "scene of the accident" unless it is necessary to prevent further injuries, to protect property or "to attend to persons injured or killed": s.64. While the Act is silent on the issue, Department of Labour policy results in an investigation into the event in order to determine whether violations of the *Occupational Health and Safety Act* or its regulations occurred. Similarly, where a fatality is associated with an elevator (which may or may not be at a workplace) the inspector, under the *Elevators and Lifts Act*, s. 15(3) conducts an investigation focussing on variances from accepted standards which may have caused the elevator accident. Both of these investigations are distinguishable from the medical examiner's whose focus is determining the medical cause of death of the individual.

Under the Newfoundland *Fatalities Investigations Act*, the issue of workplace deaths is dealt with as follows:

> 8. Where a person dies as the result of
>
> (a) a disease or ill-health;
>
> (b) an injury sustained by the person; or
>
> (c) a toxic substance introduced into the person
>
> probably caused by the person's employment or occupation or in the course of one or more of his or her former employments or occupations, the person attending the person shall immediately notify a medical examiner or an investigator.

This clause parallels clause 10(2)(j) of the Alberta Act.

7. DUTY TO NOTIFY A MEDICAL EXAMINER OF A DEATH

In Nova Scotia, police officers have a duty to notify a medical examiner of subsection 5(1) deaths under the *Fatality Inquiries Act*, and superintendents of prisons, jails or lock-ups are duty bound to report deaths in prisons or jails to a medical examiner and the Minister of Justice under regulations

to the *Corrections Act* and the *Court Houses and Lockup Houses Act*[75]. No others have this duty in statute.

However, there are statutory duties to report certain deaths to office holders who are not medical examiners under other legislation in Nova Scotia. These are:

1) under the *Motor Vehicle Act*, s. 98, duties are imposed on drivers and other occupants of the vehicle (where alive and physically able) to report accidents involving death within 24 hours to the Registrar of Motor Vehicles or to the RCMP or the police. The police are also required to report deaths to the Registrar as are medical examiners.

2) under the *Elevators and Lifts Act*, s. 15 , the owner of the elevator is required to give notice to the Chief Inspector of elevators where a fatal accident occurs in an elevator or escalator; and

3) under the *Occupational Health and Safety Act*, s. 63, employers are directed to report workplace accidents which result in death to the Executive Director of Occupational Health and Safety.

These acts are silent respecting a corresponding duty to report the death to a medical examiner.

7.1 Should the duty to report s. 5(1) deaths be expanded?

The fact that the duty to report is so limited was brought to public attention in the events surrounding the death of a patient at a Halifax hospital and the subsequent charging of a physician with murder.

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[75] *Corrections Act*, R.S.N.S. c. 103, Correctional Facilities Regulations, N.S. Reg. 248/88, s. 6(1); *Court Houses and Lock-up Houses Act*, R.S.N.S. c. 109, Lock-up Facilities Regulations, N.S. Reg. 191/89, s. 8(1) and Appendix "A", s. 6(1) [this appendix is in fact N.S. Reg. 248/88; *Court Houses and Lockup Houses Act*, R.S.N.S. c. 109, Management and Operation of Penal Institutions Regulations, N.S. Reg. 32/79, s. 6(1) and Appendix "A", s. 6(1) [this appendix is in fact N.S. Reg. 248/88].

A newspaper article reported that "none of the proper authorities was notified" of the patient's death, including "the province's chief medical examiner Dr. John Butt".[76]

An external review team investigated the death and concluded, amongst other things, that the *Fatality Inquiries Act* was "deficient in failing to mandate a report of such deaths [presumably, where an individual dies by violence, undue means or culpable negligence] to the Medical Examiner, even although this could be deemed to be a responsibility of any reasonable citizen." They recommended that the Act be amended "to include a duty on the part of any citizen" to notify the Chief Medical Examiner of a Section 5 death.[77]

At common law, it was the "duty of every person to give information which may lead to the coroner having notice of circumstances requiring the holding of an inquest into a death".[78] In Alberta and Newfoundland "any person having knowledge or reason to believe that a person has died" under the conditions set out in the legislation is required to "immediately notify a medical examiner or an investigator": Alberta, s. 10(1); Newfoundland, s. 5. Under the Ontario statute, "every person who has reason to believe that a deceased person has died" under particular circumstances "shall immediately notify a coroner or a police officer ... and where a police officer is notified he or she shall in turn immediately notify the coroner" s. 10(1).

In Newfoundland and Alberta, there is also a duty to report a death to a medical examiner where the body has yet to be located: Newfoundland, s. 16; Alberta, s. 18.

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[76] Shaune MacKinlay, "Morrison case still resonates", *Daily News*, May 3, 1998, p. 4.

[77] Queen Elizabeth II Health Science Centre. Report of the External Review Team: Review of the Investigation following the death of Mr. Paul Mills on November 10, 1996. (Halifax: the Centre, July 31 1997) at pp. 9,17, 33.

[78] *Halsbury's Laws of England*, 4th ed., Vol. 9(2) at par. 848. See also Marshall, Canadian Law of Inquests 2d ed., who cites *R. v. Kent JJ* (1809), 103 E.R. 992 as authority for a public duty at common law to report violent or unnatural deaths.

8. THE MEDICAL EXAMINER'S INVESTIGATION

The statute directs a medical examiner to "make diligent inquiry respecting the cause and manner of the death of the person" (s. 5(1)) and provides the medical examiner with powers to carry out the investigation.

In the period 1994-1997, about 12 percent of all deaths in Nova Scotia were investigated by medical examiners: Table 3. By comparison, in Ontario, coroners investigate about 40 percent of all deaths. The reason for this may well be tied to the number of deaths which are required to be reported to the coroner in that province.[79]

Absent violent or suspicious deaths, a medical examiner's "case" is typically one where there is no physician available to sign the medical certificate of death. This is discussed further at §10.1.13, attending physician.

Table 3
Deaths Investigated by Medical Examiners
Nova Scotia: 1994-1997

Cause of death	1994	1995	1996	1997
Total deaths	7,770	7,687	7,820	n/a
Total cases examined by medical examiners*	892	912	891	1081
Medical examiners' cases as a percentage of total deaths	11.48%	11.86%	11.39%	n/a

Source: Office of the Chief Medical Examiner for Nova Scotia.

When a medical examiner suspects, from his or her examination of the deceased, that a contributing factor in the death may have been neglect, a "culpable act", or a breach of the standard of care, he will notify the police that he has a suspicious death. As noted under §5.5.1, this is part of the working arrangement between police and medical examiners, and it may well be that there should be clarification of their respective roles in the revised statute.

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[79] Ontario Law Reform Commission, *Report on the Law of Coroners*. (Toronto: The Commission, 1995) at p.2.

In 1994 and 1995, the number of persons who died as the result of an assault was 14 and 16 respectively: see Table 1. Assuming a medical examiner investigates every instance of an assault causing death, it would appear that slightly over two percent of the deaths investigated by medical examiners in 1994 and 1995 involved foul play in those years.

8.1 Ought the purpose of the medical examiner's investigation into a death be clarified in the revised Act?

In Dr. Butt's view, the prime purpose of the medical examiner's investigation is to "correctly develop and interpret" five particulars in each investigation:

1. the identity of the deceased;
2. the time of death;
3. the place of death;
4. the medical cause of death; and
5. the manner of death.

A number of Canadian jurisdictions incorporate this five pronged requirement in legislation as noted in Table 4:

Table 4

What the Medical Examiner Investigates in
Selected Jurisdictions as expressed in Legislation

	Alb.	Man	Nfld.	N.S.	Que.
who deceased was [identify]	s.20(1)(a)	s.7(5)(c)	s.10(1)(a)		s.2(1)
when deceased died [date, time]	s.20(1)(b)	s.7(5)(d)	s.10(1)(b)		s.2(2)
where deceased died [place]		s.7(5)(d)	s.10(1)(b)		s.2(2)
by what means deceased died [manner of death]	s.20(1)(e)	s.7(5)(b)	s.10(1)(a)	s.5(1)	
the circumstances under which the death occurred	s.20(1)(c)	s.7(5)(e)			s.2(4)
the cause of death	s.20(1)(d)	s.7(5)(a)	s.10(1)(c)	s.5(1)	s.2(3)
any recommendation directed towards better prevention of human life where applicable					

It may be helpful to examine the terminology used in other jurisdictions:

8.1.1 *Cause of death*

In Alberta, Manitoba, and Newfoundland, a definition of "cause of death" is included in the interpretation section and is equated with the "medical cause of death". Determination of the medical cause of death is in accordance with the latest edition of the World Health Organizations's *Manual of International Statistical Classification of Diseases, Injuries and Causes of Death*.[80] Alberta, s. 1(d), Manitoba, s. 1, and the Newfoundland, s. 1(c). In Nova Scotia, the information on death certificates follows this classification, though the direction to the medical examiner is found not in the *Fatality Inquiries Act* but in the *Vital Statistics Act* (which defines a coroner to include a medical examiner):

> Medical certificate
> 17 (3) The funeral director shall forthwith after the death obtain from the medical practitioner who was last in attendance during the last illness of the deceased or the coroner who conducts an inquest on the body or an inquiry into the circumstances of the death a medical certificate in the prescribed form stating therein the cause of death according to the International List of Causes of Death, as last revised by the International Commission assembled for that purpose.
>
> Duty of medical practitioner
> (4) The medical practitioner who was last in attendance during the last illness of the deceased or the coroner who conducts an inquest on the body or an inquiry into the circumstances of the death shall, upon the request of the funeral director, complete a medical certificate in the prescribed form and cause it to be delivered to the funeral director.

The "medical certificate" referred to is that found *within* Form 6 of the Office of the Registrar General, headed "Registration of Death Certificate".

Under the Quebec legislation, "cause of death" is defined in s. 2(3) as "the disease, pathological condition, trauma or intoxications having caused, led to or contributed to the death".

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[80] Often cited as ICD-9; full reference is World Health Organization. *Manual of the International Statistical Classification of Diseases, Injuries and Causes of Death, based on the recommendations of the Ninth Revision Conference, 1975 and adopted by the Twenty-ninth World Health Assembly.* (Geneva: WHO, 1977). Statistics Canada has prepared an abbreviated list of codes (A-list) which is linked to the ICD-9 codes; Nova Scotia's office of Vital Statistics uses this abbreviated list in reporting deaths to Statistics Canada.

8.1.2 *Manner of death*

Two statutes make clear what is intended by the words "manner of death" . In Manitoba, it refers to "the way in which a person dies or a death occurs, whether natural, homicidal, suicidal, accidental or undetermined, and does not include the cause of death": s. 1. In Alberta, it is defined as "the mode or method of death whether natural, homicidal, suicidal, accidental, unclassifiable or undeterminable": s. 1(g).

8.1.3 *Circumstances of Death*

Under the Alberta, Manitoba, and Quebec statutes, the medical examiner (or coroner) is to include "the circumstances under which the death occurred" in his or her report, but there is no indication in legislation as to what these circumstances encompass. In both Nova Scotia and Newfoundland a judge at the inquest level is directed to consider "all material circumstances attending the death"(emphasis added).

In its 1995 *Report on the Law of Coroners*, the Ontario Law Reform Commission argued that the "community and family members and friends of a deceased are entitled to know the true circumstances of a death",[81] and recommended that the purpose of the coroner's initial investigation into a death (i.e. the medical examiner's investigation in Nova Scotia) be extended to include these additional objectives:

> (1) determining whether a particular death was "preventable in that it resulted from neglect, misconduct, or other culpable act", and where the deceased was a vulnerable person dependent on others, making "an assessment of the quality of that care";

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[81] Ontario Law Reform Commission. *Report on the Law of Coroners*. (Toronto: The Commission, 1995) at p.184.

(2) reaching a conclusion "whether the death was caused or precipitated by a risk or danger, including illness, that may have been amenable to correction, regulation, removal, or avoidance";

(3) "collecting, analyzing, and disseminating data about deaths, in order to assist in preventing future deaths"; and

(4) providing "the information necessary to determine whether an inquest should be conducted".[82]

To assign the duties encompassed by items 1-3 to a medical examiner (item 4 is probably subsumed under Section 8) would not only mark a profound shift in the role of medical examiners under existing law in Nova Scotia, but would require an increase in investigatory resources (how else would a medical examiner make an assessment of the quality of care, for example) and could well compromise their neutrality in many situations. In respect of the first of these additional objectives it is known that if a medical examiner suspects, from his or her examination of the deceased, that a contributing factor in the death may have been neglect or a "culpable act, he will notify the police that he has a suspicious death. As noted under §5.5.1, this is part of the working arrangement between police and medical examiners.

The underlying concern expressed by these objectives is the prevention of premature deaths which is unquestionably a worthy purpose, but is the medical examiner best equipped to perform this task? Many government departments have responsibility for the well being of Nova Scotians including the departments of Health, Labour and Community Services. Existing systems which collect information respecting particular types of deaths include, as noted earlier, fatal motor vehicle accidents which are reported to the Registrar of Motor Vehicles, and fatal workplace accidents to the Executive Director of Occupational Health and Safety. (Note that information on accidents which are not fatal are also collected) Through the analysis of the medical certificates of death, disease

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[82]Ontario Law Reform Commission. *Report on the Law of Coroners.* (Toronto: The Commission, 1995) at p.185.

related deaths are recorded in keeping with an international classification of deaths by the Office of Vital Statistics under the Department of Business and Consumer Affairs. A protocol between Vital Statistics and Statistics Canada leads to the incorporation of this data in national, as well, as provincial databases. Some of this information is published annually by the office of Vital Statistics in its annual reports.

In the instructions to the Registration of Death Certificate, a section headed "physician's statement of death" states at clause (a) that the purpose of the medical certification of death is two fold: first, to establish the fact of death, and secondly, to "provide an on-going mortality data resource for measuring health problems, guiding health programmes, and evaluating health promotion and disease control activities". This is not intended as an exclusive listing, and whether these systems are sufficient to meet the expectations set out by the Ontario Law Reform Commission, or whether they ought to be, may be an issue for discussion.

Note that under the Quebec legislation, the coroner's initial level investigation report must include "any recommendation directed towards better protection of human life, where applicable": s. 92(5).

If the essential requirement of the medicolegal investigation is agreed to be the correct identification of the five particulars cited at the beginning of this section, the legislation would be improved if these were set out. If it is decided that additional objectives should be added to the basic five, this would need to be expressly stated and appropriate resources made available to medical examiners so that these "new" objectives may be carried out.

8.2 Should the Medical Examiners' files and Medical Examiners' s. 5(2) reports be readily accessible to the public?

In the course of an investigation, the medical examiner will gather documentation about the deceased. A case file could include summaries of the deceased's medical history including copies of medical tests conducted, psychiatric history reports, reports of investigators, toxicology reports, an autopsy report, witness statements, photographs of the deceased, ambulance reports and police

reports. A completed file would also contain a copy of the report prepared under subsection 5(2) of the Act and a copy of the medical certificate of death.

All the information gathered in a medical examiner's file is subject to the *Freedom of Information Act*. Much of it is third party documentation such as hospital records, or police reports. It is the view of the Department of Justice that the information respecting the deceased attracts the privacy protections of the *Freedom of Information Act*.

The original of the medical examiner's report is filed with the Clerk of the Crown at the Prothonotary's office.[83] At this point, the medical examiner's report is available to any person who requests it. The procedure of filing the medical examiner's report with the Clerk of the Crown would appear to be a perpetuation of the practice demanded of coroners since at least the early part of the 19th century where there may have been a need to ensure that coroners did not bill the Province for inquests that had not been conducted. Also a central filing place would mean that the findings of inquests were publically accessible. [84] It is important to note that at its inception, it was the decisions, findings, or reports of *coroner's inquests* that had to be filed with the Prothonotary, *not* the reports of medical examiners.

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[83]Note that the *Prothonotaries and Clerks of the Crown Act* was repealed by S.N.S. 1996, c. 23, s.24 so these statutory positions no longer exist.

[84]The first reference to coroners in statute law was in 1767 where it is stated that the coroner will be paid 20 shillings "out of the treasury of the Province" for every inquest taken: S.N.S. 1767 (28 Geo. 3) c. XV, s.4. By 1828, the following practice was decreed under An Act relating to Coroners and their Fees, S.N.S. 1828 [9 Geo. IV] c. XVI, s.1 :

> ... every Coroner within this Province, shall return each and every Inquisition by him taken, on view of any deceased Person, before the next sitting of the Supreme Court, in the County or District, wherein such Coroners shall have Jurisdiction, to the Clerk of the Crown, or his Deputy, for such County or District, who shall thereupon file the same, and, without fee or reward, give to such Coroner a Certificate of such Inquisitions having been so returned and filed with him, and therein state the day and year when such Inquisition was taken, and when returned and filed as aforesaid; and upon such Certificate of the Clerk of the Crown, or any one of his Deputies, being filed with the Secretary of the Province, it shall and may be lawful for the Governor, Lieutenant-Governor, or Commander in Chief for the time being, by warrant under his Hand and Seal, to direct that there be paid to any such Coroner, for each and every such Inquisition so taken, returned and filed, as aforesaid, the sum of Fifty Shillings, from and out of the Treasury of the Province.

Should this requirement to file medical examiners' reports with prothonotaries be continued? In Alberta, under s. 30 of the statute, medical examiners reports are kept at the office of the Chief Medical Examiner. Each medical examiner provides the Chief Medical Examiner with a "record of the investigation and the reports, certificates and other documents" in respect of each deceased.

While it is clear that the reports of an inquest are public documents -- as an inquiry is a public event -- it may be that reports of medical examiners can be considered as something less than "public". Under current practice, the reports of medical examiners are accessible to anyone once they are filed at the Prothonotary's office. Most do not attract attention, but it is an observation of those at the Chief Medical Examiner's office that where a prominent individual has taken his own life, it is not uncommon for the particulars of the manner of death to appear in the press causing additional pain to family members.

In both Alberta and Newfoundland, medical examiners' reports are not publically accessible in the way they are in Nova Scotia. The legislation specifically provides that all the information gathered is the "property of the government of the province and shall not be released without the permission of the Chief Medical Examiner".[85] In Newfoundland it is expressed this way in the statute:

> 24 (2) On completion of an investigation and on receipt of a request from the next of kin, the executor or executrix of the deceased or other interested party, considered valid by the Chief Medical Examiner, a report shall be completed and sent by the Chief Medical Examiner to the person making the request.

The Quebec legislation distinguishes between (1) the coroner's investigation report comprising particulars of the deceased's identity, date and place of death, the probable causes of death, a description of the circumstances of death, along with any preventative recommendations the coroner may choose to make (s. 92) and (2) the accompanying documents identified under Section 93 as including, amongst other things examinations and autopsy reports, the police report, and photographs of the body. The coroner's investigation report is deemed a public document under section 96, and

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[85] Newfoundland, s. 24(1); Alberta, s. 31(1).

may be "consulted by anyone". Under circumstances described in sections 97 - 102, the accompanying documents may be released.

In reviewing the Nova Scotia Act, consideration may need to be given to balancing the public's appropriate interest in an individual's death -- to ensure there has been no foul play -- with the sensitivity the community customarily accords the family of an individual at such times.

9. INQUESTS

For hundreds of years, the main purpose of a coroner's inquest was to determine, based on the testimony of witnesses, whether it was likely that a deceased had died as a result of foul play. Where the person suspected to be responsible for the death was known, he or she would be named in the inquisition and on the strength of this, the suspect could be charged and arrested.

Inquests can no longer be used for such purposes in Canada and in recent decades their primary role has been presented as social in nature. Justice de Grandpré stated in *Faber* v. *The Queen,* [1976] 2 S.C.R. 9 at 30:

> ... the coroner is not now a part of the structure of criminal justice. The link was completely severed in 1892 .... The traditional role of the coroner, as it existed in England, disappeared, and was replaced by a duly Canadianized function, one which was not primarily of a criminal nature, but came to have a social context.

Inquests are not courts of criminal jurisdiction, nor is their purpose to punish or pursue an accused.[86] Neither is an inquest a trial, a royal commission, a public platform, or a forum for campaigning, lobbying or crusading in the interest of a particular person or cause.[87]

The purpose of the modern inquest in Canada is threefold in the view of Justice David Marshall:

1. to ascertain publicly facts relating to suspicious deaths;

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[86] *Faber v. The Queen* [1976] 2 S.C.R. 9.

[87] *People First of Ontario v. Regional Coroner of Niagara* (1991), 50 O.A.C. 90.

2. to focus community attention on those circumstances; and to initiate community response to preventable death; and

3. to serve as a means for satisfying the community that the circumstances surrounding the death of no one of its members will be overlooked, concealed, or ignored.[88]

9.1 Inquests under the *Fatality Inquiries Act*

There are no conditions surrounding a death that trigger a mandatory inquest in Nova Scotia. There are, however, two circumstances that constitute grounds for consideration of an inquest by a judge of the Provincial Court. The first evokes the criminal setting, that is where a medical examiner "is of the opinion that the death was caused by violence, undue means or culpable negligence or that there is reasonable grounds for suspecting that the death may have been so caused". The second is when a death occurs in a "jail or prison": s. 8.[89]

When these conditions exist, a medical examiner provides the Provincial Court judge with a copy of the report filed with the clerk of the Crown "together with a notice stating that the report is being transmitted to the judge of the provincial court for consideration as to whether an inquest should be held respecting the cause of death": s. 8.

The judge is not obligated to hold an inquest when he or she receives this notice from the medical examiner. He calls the inquest only when "he considers it necessary for the full investigation of the cause of death": s. 11. This statutory procedure is represented in a diagram attached as Appendix B. In practice, medical examiners are not communicating directly with the Provincial Court, but rather, the Chief Medical Examiner for the Province notifies the Chief Judge of the Provincial Court of a case which is a candidate for an inquest, takes the file to the Chief Judge and reviews it with him.

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[88] T. David Marshall, *Canadian Law of Inquests: A Handbook for coroners, medical examiners, counsel and the police*. 2d ed. (Scarborough, Ont.: Carswell, 1991), at p.2.

[89] It will be recalled that under the former *Medical Examiner (Halifax and Dartmouth) Act* there were mandatory inquests up to 1941. See §4.3.

A Provincial Court judge also has discretion to "institute an inquiry into the circumstances surrounding the alleged death" of a person whose body has not been recovered: s. 25(1).

A Provincial Court judge must hold an inquest when directed to do so by the Attorney General or the prosecuting officer of the county: ss. 10-11 and in the past decade, at least one was called by the Attorney-General. The scope of the inquest directed by the Attorney General or the prosecutor appears broader than those inquests called by a Provincial Court judge, for they may direct that an inquest be held "notwithstanding that the chief medical examiner has failed to state in his report that in his opinion an inquest is expedient respecting the cause of the death of any person, or has stated his opinion that an inquest is not expedient": s. 10. Also, Section 8, at face value, places no requirement on a medical examiner to offer such an opinion respecting "expediancy". This is a hold over from the pre-1941 *Medical Examiner (Halifax and Dartmouth) Act* which required that the medical examiner do just that.

The number of inquests held in any one year in Nova Scotia is remarkably few: indeed, since 1988, there have been a total of 20 inquests in this province as listed in Table 5.

Table 5

Inquests in Nova Scotia, 1988-May 1998

1988	4
1989	3
1990	3
1991	3
1992	3
1993	1
1994	0
1995	1
1996	0
1997	1
1998	1
Total inquests:	20

Source: Office of Chief Judge of the Provincial Court

A decade ago, there were complaints from some members of the judiciary that there were too many unnecessary inquests. In the recommendations section of a report following an inquest, one judge stated:

> Since the Act was amended to provide for recommendations of measures which might prevent a future mishap of a similar nature, it appears that the Chief Medical Examiner is recommending inquiries in what are often obvious accidental cases, simply to elicit such recommendations. That clearly was not the intention of the Act and the Provincial Court simply does not have the human resources to conduct the ever increasing number of fatality inquiries being recommended and still carry out its responsibilities in the administration of justice in this province.[90]

Some prosecutors were also of the view that there were too many inquests and were concerned about the amount of time devoted to them.

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[90]Report concerning the death of James Cyril Hersey, pursuant to Sec. 14 of the Fatality Inquiries Act, Part Five, Other Recommendations, October 21, 1989, Robert A. Stroud, Judge of the Provincial Court.

One reason why there are so few inquests is likely because there are so few "triggering" events in our existing law which can form the basis for a judge receiving notice from a medical examiner under Section 8. As a reminder, they are where the medical examiner thinks that the death "was caused by violence, undue means or culpable negligence" or where the death occurred in a "jail or prison."

It has been observed earlier, that if a medical examiner had any suspicion that a death was due to a criminal act, he or she would advise the police immediately and would surrender jurisdiction of the investigation to them. This means that the only situation medical examiners are likely to refer for consideration of an inquest is one involving death in prison.

There is also some ambiguity in Section 10. May the Attorney General direct an inquest into "any death"?, or is the Attorney General limited to calling inquests into deaths identified by the medical examiner as "caused by violence, undue means or culpable negligence ... or where death occurs in a jail or prison"?

Of the 20 inquests held in the past decade, at least one was called by the Attorney-General.[91]

9.2 Options respecting the Inquest function

If, in fact, it is only a death in prison that may be considered by a provincial court judge in Nova Scotia for an inquest, it is not surprising that inquests are seldom called in this province. In contrast, in Ontario with a population approximately eight times ours, and a *Coroner's Act* which sets out conditions for both mandatory and discretionary inquests, about 100 inquests are conducted each year. However, these 100 inquests represent less than one-third of one percent of the 32,000 deaths investigated by Ontario coroners.[92]

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[91] Inquest into death of a person with the surname Hersey (probably James Cyril Hersey). It would be necessary to review the files at the Office of the Chief Judge of the Provincial Court to determine whether there were others.

[92] Ontario Law Reform Commission. *Report on the Law of Coroners* (Toronto: The Commission, 1995) at p.38.

In considering revisions to the inquest portion of the Act, several options are open:

9.2.1 Eliminate the inquest function

One option would be to eliminate the inquest function altogether. It has been pointed out that the usefulness of the inquest is greatly reduced given that issues of individual criminal responsibility can no longer be decided in this forum. Indeed, a finding of any sort of legal responsibility may be constitutionally invalid where individual lack the protections afforded by the civil court system. It is thought that inquests may interfere with police investigations and as Judge MacDougall stated in a recent inquest report, " a fatality inquiry implies negligence or wrong doing which may have an adverse impact upon the reputation of those related to the inquiry"[93].

9.2.2 Maintain the status quo

The status quo could be continued. The Act sets out a circumscribed set of conditions when an inquest may be held, it makes no demands on the Minister of Justice or cabinet to intervene, it makes clear that a report is to be filed by the judge after the evidence has been heard, and it has particular provisions respecting standing, representation by counsel, the examination of witnesses, and the payment of certain fees.

This is in contrast to an inquiry under the *Public Inquiries Act*, which may deal with "any public matter in relation to which the Legislature may make laws": s.2. Here, a careful writing of the terms of reference is required to set the boundaries within which the inquiry is expected to be confined. The Minister must be involved in the calling of the inquiry; the commissioner or commissioners must be appointed by Order in Council in contrast to the arrangement under the *Fatality Inquiries Act* where a provincial court judge is ready to take the case; and there is no reference to the production of a report or its expected contents so that this too must be set out in the terms of reference.

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[93] Judge John B. MacDougall in the Report of an inquiry into the cause of the death of Richard Albert Clarke, on November 10, 1996 at Dartmouth, Halifax County, Nova Scotia (July 24, 1988) at p.12.

9.2.3 Expand the conditions for holding inquests

As Judge MacDougall commented in his report of the Richard Clarke inquest, the *Fatality Inquiries Act* "gives little guidance as to what ought to be considered by the Chief Judge of the Provincial Court before an inquiry is called". He recommended that the Minister of Justice review the Act and prepare guidelines to assist in determining "under what circumstances an inquiry ought to be called."[94]

In other jurisdictions, a broader range of circumstances may result in the calling of an inquest. One option for Nova Scotia would be to extend the list of conditions that could precipitate an inquest under a revised Act.

In many Canadian jurisdictions, a mandatory inquest will be called where a person dies in custody in any form of a correctional institution (Ontario, Manitoba, British Columbia, Yukon, Saskatchewan), or where a person dies while detained or in the custody of the police (Ontario, Manitoba, British Columbia, Yukon).[95] Ontario also requires an inquest, under subsection 5(2) of its Act, where a worker dies "as a result of an accident occurring in the course of the worker's employment at or in a construction project, mining plant or mine, including a pit or quarry". In Manitoba, mandatory inquests are required where a person dies while a resident of a psychiatric facility or a "development centre defined in the Manitoba *Vulnerable Persons Living with a Mental Disability Act* and where there is reason to believe that death was a result of a violent act, undue

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[94] Judge John B. MacDougall in the Report of an inquiry into the cause of the death of Richard Albert Clarke, on November 10, 1996 at Dartmouth, Halifax County, Nova Scotia (July 24, 1988) at p. 11-12.

[95] *Ontario*: where a person dies while detained by or in the custody of the police or while an inmate on the premises of any form of correctional institution: s. 10(4); *Manitoba*: where the inmate in the correctional institutional "died as a result of a violent act, undue means or negligence or in an unexpected or unexplained manner or suddenly of unknown cause": s. 19(3)(a); also where a "person died as a result of an act or omission of a peace officer in the course of duty":s. 19(3)(b); *British Columbia*: "where a person dies in a penitentiary, correctional institution, lock-up or prison, or while detained by or in the actual custody of the police: s. 10; *Yukon*: where a prisoner dies "in a prison, goal or lock-up or in the custody of the RCMP, s. 11; *Saskatchewan*: where a prisoner dies in a jail, penitentiary or lock-up or in any correctional facility: s. 9(2).

means or negligence or in an unexpected or unexplained manner or suddenly of unknown cause": s. 19(3)(a).

In Nova Scotia, there were mandatory inquests until 1942[96] where death was caused by (a) violence, (b) undue means, or (c) culpable negligence or where there were reasonable grounds for suspecting any one of these grounds. Today these conditions would provoke a criminal investigation and charge where the evidence was sufficient. Note that deaths in prisons or jails were not included in this listing.

Other Canadian legislation will direct an inquest (or give consideration to one) where conditions exist such as where a death occurs in a public institution, where there is incomplete information about a death, where the public interest would be served, or where it is in the interest of public safety. Table 6 provides a summary of such "conditions" gleaned from a number of statutes, two law reform commission reports, and a Supreme Court of Canada decision.

Table 6

Conditions for Holding Inquests

1. **Incomplete information about the death**

- where the following have not been established: cause of death, manner of death; body unidentified or not located (Alta.); [wording with similar intent found in the Ontario and Northwest Territories legislation]
- if judge considers necessary for full investigation of death (N.S.)
- to address "unanswered and essential questions about deaths" (Ontario Law Reform Commission, 1995)

2. **Institutional deaths**

- death of prisoner (N.S., PEI, Yukon); extended in the Alberta statute to include deaths in *all* categories of correctional institutions, and also to include a death occurring while deceased was *in the custody* of a peace officer; the latter is recommended by the Ontario Law Reform Commission, 1995
- death occurred in any facility defined by the *Mental Health Act* (Alta.)
- institutional deaths (New Zealand)

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[96] See §4.1.

- "to inquire into whether the community's regulatory, law enforcement, custodial, or health and safety agencies are operating effectively, fairly, and without discrimination" (Ontario Law Reform Commission, 1995)

3. Public interest/Public purposes

- desirability of public being informed (Ont., Que., NWT)
- serve the public interest (Ont.)
- protection of public interest (Nfld.)
- "identification of the exact circumstances surrounding a death serves to check public imagination, and prevents it from becoming irresponsible": *Faber* v. *The Queen*, [1976] 2 S.C.R. 9 at 30.
- "the care taken by authorities to inquire into the circumstances, every time a death is not clearly natural or accidental, reassures the public and makes it aware that the government is acting to ensure that the guarantees relating to human life are duly respected": *Faber* v. *The Queen*, [1976] 2 S.C.R. 9 at 30.

4. Safety/accident prevention

- interest of public safety (NWT, Nfld.)
- to bring dangerous practices or conditions to knowledge of public (NWT)
- to make recommendations re: better protection of human life (Que.)
- to facilitate making of recommendations to avoid preventable deaths (NWT)
- whether the drawing of attention to the circumstances of the death is likely to prevent occurrence of similar deaths (New Zealand)
- "to inquire into preventable deaths, educate the public about such deaths and their causes and promote corrective responses": (Ontario Law Reform Commission, 1995)
- facilitate making of recommendations to avoid preventable deaths (NWT)
- "to make recommendations directed to ameliorating or eliminating any risks, dangerous practices, or misconduct revealed at the inquest": Ontario Law Reform Commission, 1995)
- "examination of the specific circumstances of a death and regular analysis of a number of cases enables the community to be aware of the factors which put human life at risk in given circumstances": *Faber* v. *The Queen*, [1976] 2 S.C.R. 9 at 30.

5. Employment context

- where death occurs while individual employed on a construction site, or in a mine, pit, or quarry (Ont., and recommended to be continued as mandatory by Ontario Law Reform Commission, 1995); also recommends a review to determine whether there should be added employment contexts

6. Other

- likelihood of useful recommendations (Ont.)
- if expedient (Que.)
- whether coroner thinks fit (New Zealand); where coroner not satisfied with information (New Zealand)
- where coroner/or medical examiner is of the opinion, after investigation, that deceased died as a result of violence, misadventure, negligence, etc. (N.S., Que.)
- if judge considers necessary for full investigation of death (N.S.)
- where directed by the A.G. or Minister (N.S., Alta., Nfld.) or the county prosecutor (N.S.)
- if inquest would not impede police investigation (Que)
- suicide -- where death appears to be
- extent of allegations, rumours, etc. (New Zealand)
- desire of members of immediate family for an inquest (New Zealand)

- "to inquire into deaths that may have resulted from misconduct, neglect, or culpable conduct, in order that similar deaths may be avoided in the future": (Ontario Law Reform Commission, 1995)
- where chief medical examiner considers a review of the investigation to be necessary or desirable (Alta.)
- where next of kin of deceased, a medical examiner or other person considered an interested party request in writing and provides reasonable grounds for review (Alta.)
- where there has been the unnatural death of child (Alta.)

It would be expected that decision makers, currently a Provincial Court judge, the Minister of Justice, or a prosecutor of the county, would be assisted in knowing when to call an inquest if clearly worded criteria were incorporated in a revised act. Such criteria could be broad as in the Quebec statutes where a separate section headed "Grounds for holding an inquest" includes the following:

> 105. In determining whether it is expedient to hold an inquest, the Chief Coroner shall consider whether it is expedient to hear witnesses, particularly
>
> (1) to obtain information for establishing the probable cause or circumstances of death;
> (2) to enable a coroner to make recommendations directed to better protection of human life;
> (3) to inform the public on the probable causes or circumstances of death.

or narrow -- such as when a person died in a particular place. Or a revised statute could include both types of conditions.

9.2.4 Expand the scope of the inquest

Under the *Fatality Inquiries Act*, a judge may include recommendations in his report "with respect to measures that might prevent a future mishap of a similar nature": S. 16(3). For example, in the Joseph James Propser inquest, Judge Clyde F. MacDonald was critical of those who had not attempted to resuscitate Mr. Prosper in the New Glasgow Police Department through cardiopulmonary resuscitation though he found it "very unlikely" that Mr. Prosper would have survived if it had been administered. He recommended that the towns of New Glasgow and Westville and the Canadian Corps of Commissioners "ensure that all police officers and Commissionaires hold an accredited up-to-date certificate regarding a cardiopulmonary resuscitation

course". He also recommended that the camera surveillance and monitoring system in place at the police station be upgraded and that the booking procedures at the station be improved, although he stated that "these deficiencies did not contribute to Mr. Prosper's death".[97]

It has been advanced that the inquest can function as a tool for institution-wide changes through the direction to a judge or jury to make recommendations. In respect of coroners' juries in Ontario, the Ontario Division Court stated:

> A separate and wider function is becoming increasingly significant: the vindication of the public interest in the prevention of death by the public exposure of conditions that have threatened life. this separate role of the jury in recommending systemic changes to prevent death is becoming more and more important. the social and preventative function of the inquest which focuses on the public interest has become, in some cases, just as important as the distinctly separate function of investigation individual facts of individual deaths: *People First of Ontario et al.* v. *Porter, Regional Coroner Niagara* (1991) 5. O. R. (3d) 609 at 619.

An option for Nova Scotia might be to have revised legislation that encourages the use of the inquest as a "mini-public inquiry" under certain conditions. A Manitoba inquest provides an example of how this can occur:

Sarah Kelly was 13 years old when she was murdered by Robert Arthurson in Le Pas, Manitoba. Her death attracted great attention and people questioned "how such a horrible offence could have taken place, and why it was that Arthurson had not been effectively stopped before he was able to commit such a heinous crime".[98] Amongst those who requested an inquest was the Canadian Mental Health Association, which was of the opinion that had the recommendations from a 1992 inquest been carried through, "new and revised programs and procedures" might well have prevented the death.[99]

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[97] Prosper Inquest at p. 76-77.

[98] Report on an Inquest [under the Manitoba *Fatality Inquiries Act*] into the Death of Sarah Dawn Kelly by the Hon. Judge Howard Collerman, March 28, 1996, at p. 12.

[99] Kelly inquest, at p. 13.

Under the Manitoba legislation, a memorandum went from the Office of the Chief Medical Examiner to the Chief Judge of the Provincial Court requesting that an inquest be held and that it address the following issues:

1) Notification;
2) Predictions of dangerousness;
3) Information sharing among officials;
4) State of mental health services in the north;
5) Effectiveness of the RCMP Violent Offenders Linkage system;
6) The Child Abuse Registry;
7) Possible areas for provincial legislative reforms;
8) Possible areas for federal legislative reforms;
9) Risk estimation system for potential offenders;
10) Role of psychiatry in preventative schemes; and
11) Racism.

In his report, Judge Collerman reviewed the testimony of witnesses who were involved in the care and treatment of Mr. Arthurson over a nine year period. He concluded that the cause of Sarah Kelly's death was "strangulation by ligature at the hands of Robert Bliss Arthurson..."; he was "firmly of the view that Arthurson was not mismanaged by those who came into contact with him, and that his ultimate offending was neither predictable nor preventable". However, Judge Collerman was also of the opinion that the examination of the "systems , procedures and concepts has uncovered areas which very well may be improved upon" and he offered a number of recommendations in these areas.[100]

He further noted, however in the introduction to his report that his report would deal with some of the 11 points listed above but "in order for these subjects to be addressed fully and completely, and

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[100] Kelly inquest, at p.16-17; p.237.

not be limited by the legislative confines of the *Fatality Inquiries Act*, that it would have been preferable to have proceeded on this matter by way of a public inquiry".[101]

One commentator has labelled these sorts of inquests as "representative inquests" because the deceased's death represents a certain category of death that is (or may be) attributable to failures in the "system" to protect him or her.[102]

Recently in Ontario, the cumulative impact of recommendations from inquests was cited as key to changes in Ontario law and policy in a report released by the Ontario Chief Coroner which analyzed how the government had responded to six sets of inquest recommendations dealing with deaths of children.

The Ontario Law Reform Commission Report added a further purpose in its report on coroners stating that an inquest could serve " as a means of examining the effectiveness, fairness and lack of discrimination of regulatory, law enforcement, custodial, or health and safety agencies".

9.2.5 Less adversarial inquests

It has been observed that inquests are more adversarial today than they once were and that it would be desirable to have an inquiry method which was less "trial-like". Where questions of fact are at issue, such as the cause of death, it would not appear that popular alternatives to the court system such as mediation or negotiation would be suitable alternatives, though under certain situations, mediation might usefully be available to the family of the deceased or others as part of the process of deciding whether an inquest was needed to fully understand why the deceased came to his or her death.

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[101] Kelly inquest, at p. 14.

[102] Unidentified author; portion of paper supplied by Doug Keefe.

Even though legal liability is not an issue, few individuals would be comfortable appearing before an inquest without legal counsel. With the death of an individual as the focus of the inquiry, it is difficult to imagine what anyone would be willing to give up the due process protections present in the existing Act, not to mention those provided by the Charter. It would be helpful to have proposals for conducting inquests that might lessen the adversarial character it has acquired.

9.3 Calling of inquests

As configured, provisions in the Act allowing for a judge, the prosecutor for the county, or the Attorney General to call inquests may have been designed at one time as a method of checks and balances, spreading authority among three parties who could be seen to reflect legal, local, and general public concerns. Should we continue with this allocation of responsibility under a revised Act? One result of the present legislation is that the medical examiner, a person with considerable knowledge of the cause of death, is excluded from deciding whether or not an inquest should go forward. This limitation is placed on the Chief Medical Examiner for the Province as well.

In Quebec, it is the discretion of the Chief Coroner of the province that is pivotal to the calling of an inquest. Regular coroners do not have this authority, but where it is believed "expedient to hold an inquest" a recommendation is made to the Chief Coroner (s. 103) who may "during or following an investigation, order that an inquest be held into the probable causes and circumstances of a death if he has reason to believe that the holding of an inquest would be expedient and would not impede the progress of any police investigation" (s. 104).

In only one Canadian jurisdiction with a medical examiner system, Manitoba, does the Chief Medical Examiner have authority to call an inquest and direct a Provincial Judge to carry it out. Other medical examiners in that province have no such authority, although they may recommend to the Chief Medical Examiner that an inquest be held. In Newfoundland, the Chief Medical Examiner may make a recommendation to the Minister in respect of an inquest, while in Alberta, the Chief Medical Examiner notifies a Board, which in turns reviews the case and decides whether to make a recommendation to the Attorney General that an inquiry be held.

That said, it is evident that medical examiners in these same provinces act as gatekeepers to the inquest process. Under the Newfoundland framework, without the recommendation of the Chief Medical Examiner, the Minister will not have a report to review which might lead him to conclude that an inquest is necessary. Similarly, in Nova Scotia, according to the Act, it is the medical examiner's decision to send a notice to a Provincial Court judge along with a copy of his or her report which alerts the Court to the potential need for an inquest. In Alberta, the Chief Medical Examiner notifies a Board, which in turn reviews the case before making a recommendation or otherwise to the Minister. (Chance of this, of course, precludes the Minister learning of concerns about a death through other means.)

In those jurisdictions where inquests are conducted by judges, it is only under the Nova Scotia legislation that the Provincial Court judge has authority to decide whether or not to take the case. With the exception of the Supreme Court of Canada, in most areas of the justice system, it is unusual for a judge to decide whether or not he or she would hear a particular case, yet this appears to be the effect of Section 11 of the *Fatality Inquiries Act*. Under the Newfoundland medical examiner systems, the court is directed to conduct the inquest by the Minister (s. 26); similarly in Alberta, under s. 36. In Manitoba, a provincial court judge is directed to conduct an inquest by the Chief Medical Examiner of that province under s. 19, and by the Minister under s. 25. Under most coroner systems, the coroner who is a legal officer, makes the decision as to whether an inquest is necessary and then conducts it.

As the official with ultimate responsibility for the Act, and the person to whom the Chief Medical Examiner for the Province reports, there is reason to retain the Minister's authority to call inquests. Also vesting this authority in the Minister allows for an "appeal" from the decision of a medical examiner who has decided there is no need for a Provincial Court judge to consider the suitability of an inquest. Note however, an effect of Section 10 may be to allow a situation where the Attorney General may be perceived as countering a decision of a Provincial Court judge. Hypothetically, a judge could conclude under Section 11 that there was no need for an inquest but could be directed to conduct one by the prosecutor or the Attorney General under Section 10.

Could this situation be construed as an instance where the Attorney General or the prosecutor had "overruled" a judge?

The authority of the prosecutor of the county to call an inquest may be unique in Canada. The Public Prosecution Service will provide their views as to whether there is merit in perpetuating a right for certain prosecutors to call inquests.

In the opinion of Dr. Butt, who was involved in the drafting of the Alberta legislation, the intermediary board model established under that act to make recommendations to the Minister respecting the holding of inquests, has not met expectations and is best avoided. Whether another model of a board or tribunal having authority to call an inquest would assist the process is an option that might be considered.

9.4 Conduct of Inquests

Inquests are conducted by judges of the Provincial Court sitting alone: ss. 10-11. A judge who "receives the report of a chief medical examiner" may at his discretion refer the report to another Provincial Court judge to conduct the inquiry: s. 18(1). An inquest may be private and any person not required or permitted by the Act may be excluded: s. 12. There is no jury under the Nova Scotia legislation.

The selection of a judge to conduct an inquest is, in the opinion of Justice David Marshall, the best choice. He writes:

> The now almost-lost independence of the single coroner is best replaced ... by the institutional and individual independence of the judge. The medical examiner system, separating medical and legal functions, combined with a provincial court judge, will thus offer the best compromise. Independence will be maintained but investigations will be professional and swift, and inquest few, economical and forensically sound. The jury could be retained for public input.[103]

This model is found in the Alberta Act where the Minister ordering an inquest has the option of including "a direction that a jury be summoned for the purposes, the public fatality inquiry": s. 36(2).

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[103] Marshall, at p. 140.

Not only is the independence of judges a valued factor, but they are accustomed to evaluating evidence, and well acquainted with the procedural requirements for fair hearings. Alternatives to a Provincial Court judge conducting an inquest might include re-establishing the office of coroner to perform the inquest function only, assigning the task to commissioners as under the *Public Inquiries Act*, or adding the responsibility to the tasks of an existing tribunal or board. There would appear, however, to be no advantage in making such a change particularly in light of Justice Marshall's assessment of inquests in Canada.

The existing Act provides for the following procedural matters. Some jurisdictions such as Alberta contain additional clauses, while others scarcely mention the topic.

9.4.1 Standing

The Crown has standing under the Act, and the prosecutor (or any other counsel appointed by the Attorney-General) may attend the inquiry and examine witness: s. 13 (1). Standing is also afforded to "any person claiming to be interested" by "permission of the presiding judge": s. 13(2).

9.4.2 Witnesses

The judge is required to issue summons for witnesses required by "counsel for the Attorney General" and may do the same for other witnesses: s. 14(1). Witnesses are subject to the *Summary Proceedings Act*, s. 14(3) and are to be paid in keeping with that act: s. 14(4). There is no specific provision respecting self-incrimination.

If the judge requires that a chief medical examiner appear at the inquiry, the examiner is entitled to a fee for attending: s. 15.

9.4.3 Evidence

The report of the chief medical examiner "shall without further proof be evidence on an inquest": s. 15. There is no requirement to transcribe the evidence presented at an inquest unless it is required or requested under the *Court Reporters Act*: s. 16(1A).

The judge may dispose of exhibits presented at an inquest in any way the judge sees appropriate: s. 16(2).

9.4.4 Criminal charge

An adjournment or postponement is required pending the determination or hearing of a criminal charge, where a judge becomes aware that a "criminal charge has been preferred arising from or related to the death" : s. 17(1). With the hearing concluded or determination made, the judge may continue or "if satisfied that the circumstances of the death have been adequately examined" may then file a report with the Clerk of the Crown "making reference to the proceedings on the criminal charge: s. 17(2).

It would be helpful to have the opinion of the Provincial Court as to whether it is useful to have further directives respecting urgent procedures in a revised Act.

9.5 Inquest Findings: The Contents of the Judge's Report

There is no reference to a "verdict" in the *Fatality Inquiries Act*, but rather, at the conclusion of an inquest the *Fatality Inquiries Act* directs the judge to make a written report setting forth when, where and by what means the person deceased came to his death, his name, if known and all material circumstances attending the death": s. 16(1)(a).

This report -- the contents of which are readily recognizable as the particulars of the coroner's "inquisition" -- is then filed "with the clerk of the Crown [104] along with the notes or transcript, if any, of the evidence and any exhibits tendered at the inquest": s. 16(1)(c). Note that the judge is instructed to go further in his investigation than the medical examiner in his: the judge makes findings respecting "all material circumstances attending the death" while the medical examiner reports on "every circumstance respecting the condition of the body" under s. 5(2). There is a similar instruction in the Manitoba legislation at s. 33(1).

The judge may also include recommendations in his or her report "with respect to measures that might prevent a future mishap of a similar nature": s. 16(3).

In the opinion of Collerman, J., of the Manitoba Provincial Court, the phrase "material circumstances" permits the judge conducting the inquiry to "look beyond a simple answering of the questions 'when, where, and by what means,' and if necessary, examine in detail the broader picture within which the particular death occurred".[105]

9.5.1 Inquest conclusions

In Canada, only Newfoundland does not set out in its death investigation legislation what an inquest would determine. In the rest of the country, the issues to be determined comprise, for the most part, the elements of the traditional coroner's inquisition or verdict as seen in Table 7. It will be noticed that some of these same elements have also been expressed as the requirements of a medical examiner's investigation in Alberta and Manitoba and also in Quebec at the first stage investigation. See Table 8. (As noted above, however, under the Manitoba legislation, an inquest is to determine the "material circumstances" under which the death occurred, while at the medical examiner stage, the investigation is to be into the "circumstances".)

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[104] As noted under note 83, *supra*, this office would appear to no longer exist in statute: see *Court and Administrative Reform Act*. As with the medical examiner's report, the judge's report is filed at the Prothonotary's Office in the county where the investigation or inquiry took place.

[105] Collerman, J. at p. 229 of Kelly inquest.

An inquest cannot reach a conclusion that assigns blame for a death to a particular individual. This is so throughout Canada even where the statute permits an inquest to investigate a death "that may have resulted from misconduct, neglect or culpable conduct": see Ontario, s.31. In some jurisdictions the legislation specifically prohibits a finding of legal responsibility: British Columbia, s. 28(2); Manitoba, s. 33(2); the Northwest Territories, s. 22(b), s. 55(3); Ontario, s. 31(2) and Quebec, s. 4. In the Northwest Territories and Ontario, "any conclusion of law" is forbidden.

The Nova Scotia act is silent respecting a finding or description of legal liability. As noted earlier, a finding of criminal responsibility under the former s. 16(1)(b) was held to be *ultra vires* in 1991 and repealed in 1992. As will be discussed further under § 11, whether or not the legislation actually refers to findings of criminal or civil responsibility, decisions of the Supreme Court of Canada lead to the conclusion that it is best for decision makers to stay clear of such conclusions.

Recently in Ontario, the cumulative impact of recommendations from inquests was cited as key to changes in Ontario law and policy in a report released by the Ontario chief coroner that analyzed how the government had responded to six sets of inquest recommendations dealing with deaths of children.

All clients of children's aid societies, nine of the ten had died at the hands of a parent or step-parent. As recounted in the press, Deputy Chief Coroner, James Cairns, stated that "62 percent of the recommendations have been or will be implemented" and "26 percent are under consideration". Changes were in the process of being made to the *Child Protection Act,* the province had a "promised an infusion of $90-million for child protection"; a change in funding policy with ""budgets based on the actual number of cases handled" was to be made ; " a common data base for children's aid societies in Ontario" was to be developed; and new training for social workers with an interest in children's aid work was to take place. [106]

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[106] Jane Coutts, "Children's safety tops family rights, Ontario coroner says: comments come after release of report on six inquests in which juries found system failed", *Globe and Mail*, November 20, 1998.

Table 7
What an Inquest is to Determine

	Alb.	B.C.	Man.	N.B.	NWT	N.S.	Ont.	Que	Sask.	Nfld.
who deceased was [identify]	s.47(1)(a)	s.28(1)	s.33(1)(a)	s.26	s.55(1)(a)	s.16(1)(a)	s.31(1)	s.2(1)	s.20(1)	
how deceased came to his death		s.28(1)		s.26			s.31(1)			
when deceased died [date, time]	s.47(1)(b)	s.28(1)	s.33(1)(a)	s.26	s.55(1)(b)	s.16(1)(a)	s.31(1)	s.2(2)	s.20(1)	
where deceased died [place]	s.47(1)(b)	s.28(1)	s.33(1)(a)		s.55(1)(b)	s.16(1)(a)	s.31(1)	s.2(2)	s.20(1)	
by what means deceased died [manner of death]	s. 47(1)(e)	s.28(1)	s.33(1)(a)		s.55(1)(d)	s.16(1)(a)	s.31(1)			
the circumstances under which the death occurred	s. 47(1)(c)		s.33(1)(a)		s.55(1)(e)	s.16(1)(a)		s.2(4)		
the cause of death	s.47(1)(d)		s.33(1)(a)		s.55(1)(c)			s.2(3)	s.20(1)	

Table 8
Comparison of the Medical Examiner Stage
with the Inquest Stage in Alberta, Manitoba and Quebec

	Alberta Med. ex. stage	Alberta Inquest stage	Manitoba Med. ex. stage	Manitoba Inquest stage	Quebec Med. inves. stage	Quebec Inquest stage
who deceased was [identify]	s.20(1)(a)	s.47(1)(a)	s.7(5)(c)	s.33(1)(a)	s.2(1)	s.2(1)
when deceased died [date, time]	s.20(1)(b)	s.47(1)(b)	s.7(5)(d)	s.33(1)(a)	s.2(2)	s.2(2)
where deceased died [place]		s.47(1)(b)	s.7(5)(d)	s.33(1)(a)	s.2(2)	s.2(2)
by what means deceased died [manner of death]	s.20(1)(e)	s. 47(1)(e)	s.7(5)(b)	s.33(1)(a)		
the circumstances under which the death occurred	s.20(1)(c)	s. 47(1)(c)	s.7(5)(e)	s.33(1)(a)	s.2(4)	s.2(4)
the cause of death	s.20(1)(d)	s. 47(1)(d)	s.7(5)(a)	s.33(1)(a)	s.2(3)	s.2(3)

9.5.2 Follow-up

After the inquest report is filed, there is no direction in the Act as to what happens next. If the judge makes recommendations, who is responsible for evaluating them and ascertaining whether they should be followed-up? Ought this to be specified in the statute?

Under Section 24 of the *Canadian Transportation Accident and Safety Board Act* a procedure for follow-up is set out:

> 24(5) The Board shall
>
> > (a) during its investigation of a transportation occurrence, notify forthwith in writing the Minister of Transport and any other Minister or person who, in the opnion of the Board, has a direct interest in the findings of the Board of any of its findings and recommendations, whether interim or final, that in the opinion of the Board, require urgent action; and
> >
> > (b) on completion of its investigation of a transportation occurrence, notify forthwith in writing the Minister of Transport and any other Minister or person who, in the opnion of the Board, has a direct interest in the findings of the Board of its findings as to the causes and contributing factors of the transportation occurrence and any recommendations flowing therefrom.
>
> 24(6) A Minister who is notified of the findings and recommendations of the Board under paragraph (5)(a) or (b) shall, within ninety days after being so notified,
>
> > (a) advise the Board in writing of any action taken or proposed to be taken in response to those findings and recommendations, or
> >
> > (b) provide written reasons to the Board if no action will be taken or if the action to be taken differs from the action that was recommended,
>
> and in either case, the Minister shall make that reply available to the public.

The Quebec legislation includes a duty on the Chief Coroner to prepare an annual report for the Minister of Public Safety respecting "the activities of coroners during the preceding calendar year. The report may include the recommendations or a summary of the recommendations made following an investigation or an inquest". This report is tabled by the Minister in the National Assembly: s. 20.

The Ontario Law Reform Commission proposed that Section 4(1) of the Ontario *Coroner's Act* be amended "to provide that the Chief Coroner shall inquire as to the implementation of the jury's recommendations, or the reasons why implementation has been postponed or rejected". The

Commission also recommended that the Chief Coroner be required to provide an annual report to the Minister to be tabled in the Legislature, and that this report "should include accounts and statistical analyses of the work of the coroner system, and an analysis of the implementation of jury findings, including the specific responses of individual or agencies affected by the recommendations".[107]

9.6 Appeals, Judicial Review

In jurisdictions where there are coroner systems, there is a body of jurisprudence dealing with judicial review of the decisions made at coroner's inquests. This does not arise in Nova Scotia where the inquest is conducted by a Provincial Court judge.

After the judge has filed his report, the Nova Scotia legislation allows the Attorney General to order a further inquiry, under the *Public Inquiries Act*, where he or she "is satisfied that it is necessary or desirable in the interests of justice that another inquiry should be held": subsections 16(4) - (5).

10 RELATED LEGISLATION: PROVINCIAL & FEDERAL

10.1 Vital Statistics Act (Nova Scotia)

The *Vital Statistics Act* sets out a procedure for the registration of births, stillbirths, adoptions, marriages, and deaths. The Act also deals with the conditions under which burial permits will be issued, and how a person may change his or her name. Under clause 2(o) of the *Vital Statistics Act*, the "Minister" is identified as the Minister of Health. However, on March 28, 1996 responsibility was conferred on and assigned to the Minister of Business and Consumer Services by the Order in Council setting up that department, OIC 96-215 .

The *Vital Statistics Act* refers to "coroners" throughout the statute and provides a definition at Section 2(f) which includes "medical examiners" as coroners.

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[107] Ontario Law Reform Commission, Report on the Law of Coroners' (1995) at p. 271, recommendations 54-55.

10.1.1 Registration of Natural Deaths under the *Vital Statistics Act*

Most deaths in Nova Scotia do not require a medical examiner's investigation into their cause, and indeed, more than half of the deaths referred to medical examiners turn out to be "natural" deaths: see Table 1. About 65 per cent[108] of deaths occur in hospital, although increasingly individuals are choosing to die at home when palliative care can be provided there.

All deaths must be registered under subsection 17(1) of the *Vital Statistics Act* prior to burial: s. 20(1). What is called a "death certificate" is identified under the regulations to the *Vital Statistics Act* as a Registration of Death Certificate.[109] The form allows for the insertion of personal information about the deceased along with medical particulars respecting the death, the latter being a form-within-a-form and identified as the "medical certificate of death".

Responsibility for obtaining the "personal particulars" of the deceased is the task of the funeral director: s. 17(2). He or she is also responsible for obtaining the "medical certificate" setting out the date and cause of death from the attending medical practitioner or medical examiner: s. 17(3). A corresponding duty is placed on attending medical practitioners and medical examiners to provide the information to the funeral director when it was requested: 17(4). To complete the process, it is the duty of the funeral director under subsection 17(8) of the *Vital Statistics Act*, to file the form with the division registrar in the division in which the body was found. On receipt of the form, the district registrar, if "satisfied of the truth and sufficiency" of the information, signs the death registration form and issues a burial permit: s. 18(1). Until the burial permit is issued, a funeral may not be conducted: s. 20(3), and interment or cremation many not take place. In effect, the issuance of a burial certificate acts as a built-in check that the previous steps have been properly carried out.

Where an individual dies without medical attendance and "where there is no reason to believe" that the death was unnatural, the funeral director is required to notify "the coroner" or "the local medical

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[108] Nova Scotia. Business and Consumer Services. Vital Statistics. *Annual Report 1994* and *Annual Report 1995*, Table V.

[109] *Vital Statistics Act Regulation Respecting Forms*, s.6 (N.S. Reg. 114/73).

health officer" or a "medical practitioner designated by the coroner or the health officer" who is to complete the medical certificate: s. 17(5).

Registration of stillbirths is set out under Section 12 of the *Vital Statistics Act* and specifies that where there is no "medical practitioner in attendance at a stillbirth, the medical certificate is to be completed by "a medical practitioner or a coroner" and delivered to the funeral director: s. 12(3).

10.1.2 Registration of Unnatural, Unexpected, or Suspicious Deaths under the *Vital Statistics Act*

The *Vital Statistics Act* distinguishes the registration of natural deaths from unnatural ones, and appears to establish an implicit duty on a division registrar to communicate directly with a medical examiner where he or she has reason to believe that the death was unnatural and that an investigation has not taken place.[110] The legislation reads:

> 17 (6) Subject to subsection (7), where there is reason to believe that a person has died,
>
> (a) as a result of violence or misadventure;
>
> (b) by unlawful means;
>
> (c) as a result of negligence or misconduct on the part of others; or
>
> (d) under circumstances that require investigation, no burial permit shall be issued by the division registrar unless;
>
> (e) the body has been examined by the coroner and inquiry is being made by the coroner into the circumstances of the death;
>
> (f) the coroner has signed the medical certificate of the cause of death in accordance with subsection (4); and
>
> (g) the other provisions of this Act respecting the registration of the death have been complied with.
>
> (7) When a person dies under any of the circumstances referred to in subsection (6), if it impossible for the coroner to complete a medical certificate, the division registrar, upon the coroner releasing the body for burial, shall issue a burial permit and the coroner shall, within two days of his determining the cause of death, or the completion of his investigation, deliver or mail to the division registrar a medical certificate.

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[110] Prior to 1952, there was no specific instruction respecting unnatural deaths in the *Vital Statistics Act*.

These two subsections may well be an expression of the common law offense "to bury the body of anyone who has died a violent death before the coroner has had an opportunity of holding an inquest on it". [111]

At present, a number of funeral directors carry out the functions of division registrars and in the near future, it is anticipated that all funeral directors in the province will be appointed as division registrars under the *Vital Statistics Act*. This has been the recommendation of the Licenses, Permits and Approvals (LPA) Taskforce.

Once the new appointments are made, the funeral directors, who are responsible for gathering the information respecting the deceased under Section 17, will be able to issue burial permits directly rather than having to travel to a deputy registrar's office. This new system will require training for funeral directors, and will also require that Vital Statistics monitor the process to see that procedures are being correctly followed.

10.1.3 Sections of the *Vital Statistics Act* to be considered for amendment

Several Sections of the *Vital Statistics Act* appear to require change.

Definition of "coroner": Under clause 2(f), a coroner is defined to include "a chief medical examiner and a medical examiner appointed under the *Fatality Inquiries Act* and a judge of the provincial court who conducts an inquest under that Act". As we know, the office of coroner in Nova Scotia in statute was abolished in 1963 and no one has been appointed as a coroner in the intervening 35 years so the continuing use of the term is inappropriate on those grounds alone. In addition, problems arise with this definition because medical examiners do not have the quasi-judicial functions that coroners once did and Provincial Court judges do not have the medical training of medical examiners. The offices are not interchangeable.

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[111] *Halsbury's Laws of England*, 4th ed., Vol. 9(2) at para. 848.

This produces a curious result as illustrated in these examples:

> 17 (2) The funeral director shall forthwith after the death of any person obtain the personal particulars of that person from
>
> (f) the coroner who has been notified of the death and has made an inquiry or held an inquest regarding the death

If we were to read "a judge of the provincial court who conducts an inquest" for the word "coroner" in clause (f), a perplexing situation arises. Provincial Court judges are not notified of deaths (as medical examiners are under s.5(1) of *Fatality Inquiries Act* nor is it within their expertise to conduct a medical examiner's investigation. Further, it is not <u>any</u> Provincial Court judge who is suggested here but rather the one who has conducted an inquest. In our time, inquests do not usually occur within days of a death but rather months or even years later so a "judge" cannot in fact play the old coroner's part in this clause. At the same time, the clause does not suit the role of medical examiners because they have no authority to conduct inquests.

Similar problems are found in subsection 17(4):

> 17 (4) The medical practitioner who was last in attendance during the last illness of the deceased or the coroner who conducts on inquest on the body or an inquiry into the circumstances of the death shall ... complete a medical certificate in the prescribed form...

Medical examiners cannot substitute for coroners in the conduct of inquests (probably what is intended by "an inquiry into the circumstances of the death" when compared with the "inquest upon the body") and a Provincial Court judge is not a suitable substitute when it comes to the completion of the medical certificate of death.

Other difficulties present themselves when the definition of coroner under the *Vital Statistics Act*, and the Registration of Death form issued under regulations to this legislation are examined together. The "medical certificate of death" contained within the registration form may be completed under subsection 17(4) by a coroner who, according to the statute, may be either a medical examiner or a Provincial Court judge who conducts an inquest. However, the form itself specifies that the death certificate is to be signed by the "last attending physician" or a "medical examiner". The word

"coroner" does not appear anywhere on it. There are similar difficulties in other provisions of the Act and it should be reviewed carefully to clear up these anomalies.

Releasing body to a medical examiner: A number of years ago, some hospital administrators were reluctant to release bodies to medical examiners on the grounds that clause 20(2)(b) of the *Vital Statistics Act* prohibited the removal of the body from the hospital. The provision reads:

> 20 (2) Unless a statement in the prescribed form respecting the death of the person has been completed
>
> (b) no person shall remove or permit the removal from a public or municipal hospital or institution of the body of a person who has died therein.

A legal opinion that the *Fatality Inquiries Act* prevailed over the *Vital Statistics Act* was circulated in 1991 and the issue does not appear to be a difficulty today. Nonetheless, the tension between the two enactments should be resolved in the revision process.

Attending physician: The *Vital Statistics Act*, ss. 17(3)-(4) requires that the medical certificate of death be signed by the coroner or the "medical practitioner who was last in attendance during the last illness of the deceased". This language is also found in the Ontario *Vital Statistics Act*, s. 21(3) where a medical practitioner "who has been in attendance during the last illness of a deceased person" may sign the medical certificate of death, as may a medical practitioner "who has sufficient knowledge of the last illness", and in the Manitoba *Vital Statistics Act*, s. 14(3)where "the duly qualified medical practitioner last in attendance during the last illness of the deceased" is directed to certify the cause of death on the prescribed form.

Line 33 of the Nova Scotia "Medical Certificate of Death" enclosed within the Registration of Death form (Form 6), appears to require that a statement certifying the date and causes of death be signed by either an "attending physician" or a medical examiner. Under Line 34 of the form, the signatory is to indicate whether he or she is the "last attending physician" or a "medical examiner". Line 35 uses the same terminology. The individual who signs the medical certificate of death is to identify

under Line 25, Cause of Death, the immediate cause of death, antecedent causes, (if any) and other significant conditions contributing to death but not causally related to the immediate cause.

There appears to be no definition of an "attending physician" in any Nova Scotia legislation. The *Dictionary of Canadian Law* defines the words as: "the physician to whom responsibility for the observation, care and treatment of a patient has been assigned" and this is echoed in the Newfoundland *Mental Health Act*, s. 2(b) where the words mean "the physician who is given responsibility for the observation, care and treatment of the patient during the period a certificate or renewal of a certificate is in force". The words do not appear to have been judicially considered.

Under a several Ontario regulations, the words are defined in a number of ways: for example, under regulations to the *Ambulance Act* as "a physician who is aware of a patient's condition and who accepts responsibility for the patient", and under the *Community Psychiatric Hospitals Act*, as "the medical practitioner who attends a patient in a hospital".[112]

Problems in identifying the causes of death may arise when a patient is seen only briefly by a physician before death and that physician knows nothing or very little of the patient's medical history. It is not unusual for a patient to be rushed to hospital and to have death occur *en route* or in the emergency department. Under such circumstances, it is unlikely that the physician in attendance would be sufficiently familiar with the medical history of the deceased to complete the medical certificate of death in keeping with the World Health Organization's *International Statistical Classification of Diseases, Injuries and Causes of Death* .

This issue was addressed by the British Committee on Death Certification and Coroners in its 1971 report where it stated that an "accurate diagnosis of the cause of death is based on first hand knowledge of the patient's condition before death", and that barring an autopsy recent clinical observation would be the most "accurate factor" in diagnosing the cause of death. The Report recommended that a physician certifying a death must have "recent knowledge of the deceased

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[112] *Ambulance Act*, O. Reg.810/93, s.1(1); *Community Psychiatric Hospitals Act*, O.Reg. 345/91, s. 1. Other definitions are found as follows: *Homes for Retarded Persons Act*, O. Reg. 636/93, s. 13(1); *Hospital Management Act*, O.Reg. 106/96.

person's illness", which was not delineated in terms of a "precise number of visits" but rather as having seen the deceased at least once during the seven days preceding death. The certifier must "inspect" the body and attest to both the "fact" and "cause" of death. Where he or she is unable "on reasonable grounds" to certify the medical cause of death "with accuracy and precision" the death is to be reported to an appropriate authority for investigation.[113]

Much of this approach is reflect in the Alberta *Vital Statistics Act* under Section 15:

> 15(1) In this section "International Classification" means the International Statistical Classification of Diseases, Injuries and Causes of Death as last reviewed by the International Conference assembled for that purpose and published by the World Health Organization.
>
> 15(2) When
>
> (a) a physician
>
> (i) has attended the deceased person in relation to his final illness at least once during the 14 days immediately preceding the death,
>
> (ii) is able to certify the medical cause of death with reasonable accuracy, and
>
> (iii) has no reason to believe that the deceased died under circumstances which require the notification of a medical examiner under the *Fatality Inquiries Act*,
>
> (b) the death was natural or occurred during an operative procedure or within 10 days of an operative procedure and a physician
>
> (i) is able to certify the medical cause of death with reasonable accuracy, and
>
> (ii) is authorized to complete and sign the medical certificate of death under section 20(7) of the *Fatality Inquiries Act*,
>
> or
>
> (c) a medical examiner conducts an investigation into the death pursuant to the *Fatality Inquiries Act*,
>
> the physician or the medical examiner, as the case may be, shall within 48 hours of the death, complete and sign a medical certificate in the prescribed form stating therein the cause of death according to the International Classification.

Subsections 15(3)-(4) treat how and when "interim" medical certificates of death may be issued, while subsection 15(5) directs what is to happen where there is no physician in a position to sign a certificate:

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[113] Gt. Britain. Committee on Death Certification and Coroners. *Report of the Committee on Death Certification and Coroners*. Cmnd. 4810. (London: H.M.S.O., 1971), at 40-48. (Also known as the Broderick Report, after the chair.)

15(5) When

(a) a death occurs without the attendance of a physician in relation to the final illness of the deceased during the 14 days immediately preceding the death, or

(b) the physician who attended the deceased is for any reason unable to complete the medicate certificate within 48 hours of the death,

the funeral director or the physician, as the case may be, shall forthwith notify a medical examiner who shall thereupon conduct an investigation into the death in accordance with the *Fatality Inquiries Act*.

Under the Newfoundland *Fatalities Investigations Act*, there is a specific provision respecting deaths occurring in hospital emergency departments:

6 (2) Where a person is declared dead on arrival or dies in the emergency department of a health care facility as a result of a condition referred to in section 5, the person responsible for that facility shall immediately notify a medical examiner or an investigator.

10.2 Other Nova Scotia legislation

References to medical examiners, coroners or the *Fatality Inquiries Act* are found in the following Nova Scotia statutes or regulations:

10.2.1 *Anatomy Act*

This legislation instructs "every chief medical examiner and medical examiner and every officer of any town, city, district, municipality or county, " to notify the Inspector of Anatomy respecting unclaimed or unidentified bodies, or where there is a deceased who requires burial or cremation at public expense: ss. 5(1), (3); s.14. Under subsection 5(1), the bodies are to be delivered to the Inspector who will remove them "within this province" to "any legally established medical school or college for the advancement of anatomical or pathological science". The penalty for failure to comply with this provision is between $100 and $200: s. 11(1).

Other office holders identified as "every superintendent, manager, keeper or officer in charge of any municipal home, prison, morgue, hospital or other public institution, having charge or control of dead bodies who previous to death were being maintained at the public expense" is required to deliver the deceased to the Inspector who will take the body to a medical school.

A process for medical examiners to follow in dealing with the burial or cremation of the unclaimed is required and it may be appropriate to provide direction to medical examiners in a revised *Fatality Inquiries Act*.[114] The Department of Health may wish to give consideration to a revision of the *Anatomy Act* in light of the instruction respecting persons "who previous to death were being maintained at the public expense".

10.2.2 *Children and Family Services Act*

Under subsection 5(4) of the *Fatality Inquiries Act*, where a medical examiner is suspicious that a child under the age of 16 may have died "by violence, undue means or culpable negligence" he or she is to report the death to the child abuse register. The medical examiner cannot express an opinion respecting the culpability of any person in the death of another, but by reporting the name of a child whose death may be linked to abuse the Department of Community Services is notified that there may be a need to investigate the household of the dead child where there may be other children at risk.

The *Children and Family Services Act*, clause 24(2)(c), reinforces the duty on medical examiners to report a suspicion of abuse. In this legislation, the suspected abuse is to be reported to particular "agencies" defined in the Act. Subsection 24(1) states that a child who has "'suffer[ed] abuse', is a child " in need of protective services within the meaning of clause (a), (c), (e), (f), (h, (i) or (j) of subsection (2) of Section 22."

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[114] It may be recalled that in the earliest Nova Scotia statute respecting coroners, the coroner was to look after the burial in such instances and if it was properly done, he would be reimbursed by the Province.

Looking at subsection 22(2), children are described to be at "substantial risk" of abuse under conditions such as where they have "suffered emotional harm, demonstrated by severe anxiety, depression, withdrawal", or where they are in situations of "physical or emotional harm caused by being exposed to repeated domestic violence by or towards a parent ". In each clause listed under s. 22(2), it is assumed the child is alive. Sadly, the dead child that the medical examiner sees is no longer in need of "protective services", and if the medical examiner were suspicious that abuse had led to death, he or she would have reported this to the police.

The Department of Community Services may wish to examine the inter-relationship of Sections 22 and 24 of the *Children and Family Services Act* in the context of the medical examiner's duties and provide advice whether the direction to report the death of a child due to suspected abuse under subsection 5(4) of the *Fatality Inquiries Act* is sufficient or whether rewording is required in one or both acts.

10.2.3 *Coal Mines Regulations Act*

Section 67 of this legislation excludes the operation of the *Fatality Inquiries Act* in the event of a mine-related death and provides for an alternate method of inquiry under "one or more competent persons to be called 'special examiners' ". These examiners have three-fold powers: those of commissioners under the *Public Inquiries Act*, those of an inspector under s. 66 of the *Coal Mines Regulations Act*, and those of a medical examiner. From the language of Section 67, it would appear that the intent of this Section was to establish the special examiner as a specialized type of coroner and that the words "medical examiner" were substituted without an acknowledgement that the tasks of the coroner and the medical examiner are fundamentally different. An examination of revisions to the Act between 1954 and 1967 supports this assumption.

Section 86 of the *Occupational Health and Safety Act*, S.N.S. 1996, c.7 repeals the *Coal Mines Regulation Act*, but that Section has yet to be proclaimed., so the Act remains in force.

10.2.4 *Corrections Act*: Correctional Facilities Regulations (N.S. Reg. 248/88 & Appendix A)

Subsection 6(1) of regulation 288/88 directs the Superintendent of a correctional facility to "immediately report" the death of an inmate to "the medical examiner and the Minister". These words are repeated verbatim in Appendix A.

10.2.5 *Costs and Fees Act*

The office of coroner is referred to twice in the Schedule to Part I of the *Costs and Fees Act*. Under the heading "Fees to be taken at the Department of the Attorney General", the "commission for coroner" is stated to be $5.00. Further along in the listing of departments with associated fees, there is a heading "Coroner's Fees", which reads that the coroner will be paid the same fees as the sheriff "where he discharges the duties of a sheriff".

As Nova Scotia no longer has coroners, and there is no evidence elsewhere that medical examiners are to assume the duties of sheriffs (as coroners sometimes did in the past), these Sections are spent.

10.2.6 *Court Houses and Lockup Houses Act*: Regulations (N.S. Reg. 191/89)

Subsection 8(1) requires the officer in charge of a lock-up, to notify the police and next of kin immediately of the death of a detained person, and to ensure that "the inspector and the chief medical examiner or medical examiner for the county where the lock-up facility is situate are advised of the death". An Appendix A , identical in wording with Appendix A under the *Corrections Facilities Regulations*, appears to be appended, and s. 6(1) instructs the Superintendent to report the death of an inmate to a medical examiner or the Minister.

An earlier regulation, entitled *Management and Operation of Penal Institutions Regulations*, made under the *Court Houses and Lockup Houses Act*, (N.S. Reg. 32/79), s. 6(1) is worded identically with s.6(1) of Appendix A and s. 6(1) of Reg. 248/88.

10.2.7 *Emergency Measures Act*: *Civil Emergency Planning Regulations* (N.S. Reg. 82/71)

As noted in §5.6, there is a need to update clause 4 B(e) of the regulation which states that, in the event of peacetime disaster or war emergency, the Department of Justice and Attorney General will provide the services "of the Supervising Coroner to the Department of Health for the development and operation of an Emergency Mortuary Plan".

10.2.8 *Evidence Act*

There are references to coroners in Section 20 of this statute, which deals with evidence given before judicial proceedings. Here a copy of evidence given before a coroner "in any province of Canada, or any court in any British colony or possession, or any court of record of the United States of America, or of any state of the United States of America ..." may be given in Nova Scotia courts. The existence of coroners' inquests in other jurisdictions would suggest that this provision should continue, although one wonders whether the Section would be applicable to evidence given in Singapore or South Africa given the demise of the British empire.

10.2.9 *House of Assembly Act*

Clause 20(1)(c) of this statute establishes that a person who is a "justice of the peace, notary public, commissioner for administering oaths or coroner" cannot be rendered ineligible to sit or vote in the House because he or she holds such an office. This statute should be amended to remove the word "coroner".

10.2.10 *Metalliferous Mines and Quarries Regulation Act*

Under Section 9 of this act, a "medical examiner" is barred from holding an inquest into the death of a person killed in a fatal accident and a "special examiner" is authorized to carry out the

traditional duties of the coroner. Medical examiners, under Nova Scotia law do not conduct inquests and this would appear to be another example of where the word "medical examiner" was simply substituted for "coroner".[115] Unlike the *Coal Mines Regulation Act*, the *Fatality Inquiries Act* is not deemed inoperative.

This act was repealed by Section 87 of the *Occupational Health and Safety Act*, S.N.S. 1996, c.7 but that Section has yet to be proclaimed so it remains in force.

10.2.11 *Human Tissue Gift Act*

This statute deals with the donation of tissue from both living and deceased donors. Under Section 7, "the chief medical examiner" is called in and entitled to give advice respecting tissue removal at death where "in the opinion of a physician the death of a person is imminent by reason of injury or disease and the physician has reason to believe that Section 5 of the *Fatality Inquiries Act* may apply when death does occur". Whether the reference to this power is given to all chief medical examiners under the *Fatality Inquiries Act* or "the" Chief Medical Examiner for the Province is ambiguous and there is a need to clarify the wording.

Subsections 6(1) and (2) of the *Human Tissue Gift Act* preclude "the chief medical examiner or medical examiner" from providing consent for tissue transplant where a deceased has not given consent or is incapable of giving it. Section 15 states that with the exception of Section 7, there is nothing in the act which "affects the operation of the *Fatality Inquiries Act*".

10.2.12 *Motor Vehicle Act*

Subsection 98 (8) places a duty on "a medical examiner or other official performing like functions" to report a motor vehicle related death to the Registrar of Motor Vehicles.

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[115] This wording also appeared in the former *Court Reporters Act*, s. 1(a) where a court was defined to include "city court of any city, judge of the provincial court ... medical examiner, commissioner .... sheriff, arbitrator ..." This Act was repealed by the *Court and Administrative Reform Act*, S.N.S. 1996, c. 23, s.8.

As noted earlier, in practice, medical examiners rely on the police to file the accident reports specified under subsections 98(3) and (4). The Department of Transportation may wish to consider whether it is necessary to continue with these provisions or whether the act should be amended to remove them.

10.3 Federal legislation

For the most part, where federal statutes reference coroners, it is in respect of their role as judicial officers, thus under Section 23 of the *Evidence Act*, evidence given before a coroner is evidence of a judicial proceeding, and under the *Criminal Code of Canada* a judicial proceeding is defined to include a proceeding before a coroner at s. 118, evidence taken by a coroner is referred to in ss. 551, 561(3)(b), 561(5), 565(3). Paragraphs 746.1(2)(c) and 746.1(3)(c) deal with attendance at coroners' inquests by persons sentenced to life imprisonment without eligibility for parole for a specified period of years. Under the *Supreme Court Act*, where a sheriff, identified as an *ex officio* officer of the Court under subsection 92(2), is disqualified for some reason, "the process shall be directed to any of the coroners of the county or district": s. 94(3). There are also references to coroners in the regulations to this Act.

The *Criminal Code* establishes under section 128 that a coroner, like a peace officer, is guilty of an indictable offence where " being entrusted with the execution of a process" he or she wilfully (a) misconducts himself in the execution of the process, (b) makes a false return to the process".

The effect of a finding by a coroner's inquest is addressed in two situations. Subsection 576(3) of the *Criminal Code* establishes that "No person shall be tried on a coroner's inquisition" and effectively breaks the ancient tie of the coroner to the administration of criminal justice. The *Canada Shipping Act* specifies that the Minister, following an inquiry, may suspend or cancel the certificate of competency or service of " any master, mate or engineer who has been guilty of a criminal offence or has been blamed by any coroner's inquest in respect of the death of any person": s. 505(c).

In none of these federal statutes is there any reference to a medical examiner; neither would the pre-inquest death investigation appear to be part of what these legislative provisions contemplate. However, the *Canadian Transportation Accident Investigation and Safety Board Act* which applies to air, marine, and locomotive occurrences, defines a " coroner" to include "a medical examiner or other person carrying out the duties and functions of a coroner": s.2. The statute anticipates the Board's involvement with provincial coroners in the pre-inquest period under section 16:

> 16. The Board and the Directors of Investigations shall take all reasonable measures to ensure that the investigation procedures and practices that they follow in relation to transportation occurrences are compatible with
>
> > (b) investigation procedures and practices followed by police and coroners in the provinces and by regulatory bodies established to administer petroleum activities in the offshore areas,
>
> and the Board shall make all reasonable efforts to enter into agreements with the governments of the provinces and with those regulatory bodies in order to ensure that the procedures and practices followed by the Board and the Directors of Investigations are as compatible as possible with those followed by police and coroners in the provinces and by those regulatory bodies.

Other sections appear to anticipate the judicial office of the coroner. Information collected by the Board is available upon request to a coroner who asks for it "for the purpose of an investigation that the coroner is conducting": i.e., on-board recordings, s. 28(5)(b); communication records, s. 29(5)(b); and statements, s. 30(4)(b). Procedures to be followed where the production of this information is requested for discovery are set out in subsection 28(6) in respect of on-board recordings and in subsection 30(5) regarding statements and involve the coroner exercising a court-like function. Similarly, under subsection 32(3) a coroner or court may order an investigator to testify at a proceeding but unless it is for "special cause", the investigator's evidence may be admitted by affidavit.

The *Canada-Nova Scotia Offshore Petroleum Resources Accord Implementation (N.S.) Act* does not refer to the actions of medical examiners or the *Fatality Inquiries Act* but does provide a procedure for conducting an inquiry into any incident resulting "in death or injury or danger to public safety or the environment" in the offshore: s. 162(1)-(1A). A death occurring offshore within or without Canadian waters, would be outside the territorial jurisdiction of any medical examiner. However,

once the deceased was brought to land and the medical examiner was notified of the death, it would seem that s. 5(2) of the *Fatality Inquiries Act* would begin to operate. A death certificate would have to be signed and it would be likely that a medical examiner would be involved as the procedure set out under the *Canadian Transportation Accident Investigation and Safety Board Act* anticipates.

11 CONSTITUTIONAL ISSUES

Four areas where constitutional issues might arise are reviewed in this section: whether death investigation legislation is within the legislative capacity of a province; whether individuals charged or likely to be charged with a criminal offense ought to be compelled as witnesses at an inquest; the extent to which inquest findings may implicate named individuals; and authority of medical examiners and coroners to enter buildings without a warrant to remove a body.

11.1 Legislative capacity of a province to legislate in respect of death investigations

Historically, the coroner's court was a court of criminal record, but after 1867, all criminal law came under the exclusive legislative authority of Parliament under s.91 of the *Constitution Act, 1867*. Today, coroners or medical examiners act under the authority of provincial statutes and all of the provinces and the territories have their own statutes that deal with death investigations and inquests. There is no comparable federal legislation, though as noted under §10.3 above, Parliament has legislated in respect of the coroner's judicial duties and also in respect of coordinating the investigatory activities of coroners or medical examiners at the time of a transportation accident.

The authority of a province to set up a medical examiner system of death investigation does not appear to have ever been an issue before a Canadian court. In contrast, aspects of coroners' legislation have been dealt with by the Supreme Court of Canada on several occasions, but as Justice David Marshall observes, the question of whether it is *intra vires* a province" remains unanswered although progress is being made".[116]

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[116] Marshall, at p.22.

It is significant that the portions of the coroner's law subjected to scrutiny have not been those portions of a provincial statute dealing with the first level investigation of the coroner, i.e. that which would be comparable with the medical examiner's examination. The areas of concern have been related to the coroner is his office as a quasi-judicial officer.

11.2 Compelling witnesses to give testimony where they have been charged or are likely to be charged with a criminal offense

Two Supreme Court of Canada cases have dealt with the constitutionality of compelling witnesses to give testimony at inquests or public inquiries where they have been charged with a criminal offence, or are likely to be charged.

In 1965, the Supreme Court of Canada in *Batary v. A.G. of Saskatchewan*, ruled that compelling a witness to testify at an inquest where the witness had been accused of murder in the same death was *ultra vires* the Province. [117] In *Faber* v. *The Queen*, the witness had *not* been charged with any criminal offence at the time of the inquest but refused to testify and was charged with contempt. The witness applied for prohibition to the Quebec Court of Queen's Bench and in time the issue reached the Supreme Court of Canada where the majority dismissed the appeal holding that the inquest had long since ceased to be a matter of criminal jurisdiction and was a Canadianized method for investigating particular categories of deaths in order to assuage public concern, identify protective measures, and acknowledge that the state was not ignoring any death which was out of the ordinary.

As noted in §4.7.4, where a criminal charge is laid in connection with a death that is the subject of an inquest, Nova Scotia law requires the judge to adjourn or postpone the inquest. After a determination has been made respecting the criminal charges, the inquest may proceed. Alternatively, if the judge is satisfied that the issue has been dealt with adequately under the criminal

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[117] *Batary v. A.G. of Saskatchewan*, [1965] S.C.R. 465.

process, he or she prepares the report: Section 17.[118] Note as well that Section 11(*c*) of the Charter gives any person "charged with an offence" the right "not to be compelled to be a witness in proceedings against that person in respect of that offence".

In keeping with the Charter and federal and provincial evidence acts, testimony given by a witness at an inquest cannot be used against him in a subsequent proceeding. This is codified in the Alberta legislation as follows:

> 42 (1) A witness at a public inquiry is deemed to object to any question asked him if the answer to the question may tend to incriminate him or may tend to establish his liability to a civil proceeding at the instance of the Crown or of any other person and no answer given by a witness at a public inquiry shall be used or be receivable in evidence against him in any trial or other proceeding thereafter taking place other than a prosecution for perjury in the giving of that evidence.
>
> (2) When it appears at any stage of the public fatality inquiry that a witness is about to given evidence that would tend to incriminate him, it is the duty of the judge to inform the witness of his rights under section 5 of the *Canada Evidence Act* (Canada).

In Quebec, the latter clause appears as:

> 127. The coroner shall inform witnesses of their right to request the protection of section 5 of the *Canada Evidence Act* (Revised Statutes of Canada, 1985, chapter C-5) regarding any question tending to criminate him.

11.3 The extent to which inquiries may make findings that may implicate named individuals

In this decade, the Supreme Court of Canada has ruled that a commission of inquiry will be acting within its jurisdiction where it looks at system-wide causes or failures which have led to particular death: Krever (1997), 207 N.R. 1; Westray (Report of the Westray Mine Public Inquiry, Justice K. Peter Richards, Commisioner: November 1997). However, should a commission narrow its focus

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[118] In some jurisdictions, the Minister has authority to direct an inquest of a charged person: Ontario, s. 27(1); Saskatchewan, s. 10(1); Quebec (after judgment on criminal proceedings "has acquired the status of *res judicata*", s. 156); in Manitoba, the presiding provincial judge has discretion to postpone or adjourn the inquest under these circumstances: s. 34(1).

to the "alleged commission of specific offences by named persons" it would be transgressing upon the criminal law power and would be *ultra vires* the province: Lamer, J. in *Starr* v. *Holden* [1990] 1 S.C.R. 1366 at p.1397-8.

Peter W. Hogg explains this issue as follows:

> Because provincial authority over the administration of justice extends to criminal justice, the province may establish a commission of inquiry into matters forming part of criminal justice, and may give to the commission powers of investigation that include the compelling of oral testimony and production of documents. What the province may not do is authorize an inquiry into the commission of a specific crime. That is a matter coming within the exclusive federal jurisdiction over criminal procedure. The main objection to a provincial inquiry into the commission of a crime is that the inquiry would probably have the effect of denying to the suspected person the right to remain silent and other safeguards of federal criminal procedure.
>
> The broad power of the provinces to investigate the operation of the criminal justice system is illustrated by decisions upholding a provincial coroner's inquest into a death by homicide, a provincial inquiry into organized crime in the province, a provincial inquiry into illegal acts by the police, a provincial inquiry into baby deaths at a hospital, a provincial inquiry into injuries suffered by a prisoner in police custody, and a provincial inquiry into the investigation, charge, prosecution and conviction of a man wrongly convicted of murder. In each of these cases, it was likely that the inquiry would reveal the commission of a crime; that the person suspected of committing the crime would be compelled to testify; and that the person suspected of committing the crime would, after the inquiry, be charged with the crime. But in each case the inquiry was upheld. The Court held that establishing the responsibility for a specific crime was not the main purpose of the inquiry, which was addressed to broader issues associated with the proper functioning of the criminal justice system.
>
> The tendency to uphold provincial public inquiries into criminal justice was checked in ***Starr* v. *Houlden*** (1990). In that case, the Supreme Court of Canada, by a majority, struck down a provincial inquiry into dealings between public officials and an individual and a corporation, who were both alleged to have made improper payments to public officials. The terms of reference of the inquiry expressly forbade the commissioner from expressing any conclusion as to the criminal responsibility of any individual organization. Nevertheless, the Court held that the commission of inquiry was, in pith and substance, "a substitute police investigation and preliminary inquiry into a specific offence".[119]

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[119] Peter W. Hogg, *Constitutional Law of Canada*. Loose-leaf ed. (Toronto: Carswell) at §19.7

A finding of civil responsibility is equally troublesome, for such a conclusion may compromise a witness's rights to a fair and impartial hearing. While Section 13 of the *Charter* affords a witness the protection of not having any incriminating testimony given in one proceeding used against them in another, it will not assist them in securing counsel to defend themself at the inquest or in protecting their reputation. In David Marshall's view, inquests often take on the characteristics of a discovery and may result in the "destruction of an individual's or institution's reputation prior to any finding of guilt and in some cases may prejudice the possibility of a fair trial thereafter".[120]

11.4 Authority of medical examiners and coroners to enter buildings without a warrant

Another potential constitutional issue is whether it is necessary for a medical examiner or coroner to obtain a warrant before he or she enters a premises to remove a body. Subsection 19(1) of the Nova Scotia act allows a medical examiner to enter any premises where "a dead body, the subject of an inquiry under this Act, is suspected to be and for such purpose". Should the medical examiner be refused access to the body, he may "without warrant, enter any dwelling house or other building and remove the body". There is no requirement for a medical examiner to have a warrant before entering a premises in either Alberta or Newfoundland.

The Ontario Law Reform Commission was of the view that it was "reasonable and justifiable" for coroners to enter buildings without a warrant to remove a body and to seize relevant items.

Beyond this, however, if

> ... a coroner believes on reasonable and probable grounds that entry, search, and seizure powers are necessary to continue an investigation, prior authorization should be obtained from a justice of the peace. We are concerned to ensure that coroners have proper authority to carry out their investigative functions without violating the constitutional rights of others.[121]

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[120] Marshall, at p. 109.

[121] Ontario Law Reform Commission Report, p. 198.

The fact that a 911 emergency system now operates in Nova Scotia makes the recently decided Supreme Court of Canada case *R.* v. *Godoy* (1998), 168 D.L.R. (4th) 257 of some interest, for in most situations in this province, it would be a 911 call that would give notification of the death, and in fact it will be the police and an ambulance which will make the initial response.

In *Godoy*, the police responded to an interrupted 911 call . On arriving at the dwelling, they were denied entry by Mr. Godoy but they persisted and found his wife crying with a bruise above one eye. She said Mr. Godoy hit her. The accused was arrested for assaulting his wife but at the trial the Judge dismissed the charge stating the entry of the premises was illegal on the grounds that the right to privacy under Section 8 of the Charter was violated. The Supreme Court of Canada gave short shrift to this argument finding both common law and statutory duties (*Ontario Police Services Act*) of the police to protect life made entry reasonable and justifiable.

12. DISINTERMENT (EXHUMATION)

Authority to disinter or remove a "buried human body" lies with the Attorney General or the medical health officer. Section 57 of the *Health Act* reads:

> 57 No person shall disinter or remove a buried human body except at the instance of the Attorney General unless with the written permission of the medical health officer for the place in which the body is buried.

Under Section 18 of regulations to the *Cemetery and Funeral Services Act*, "no operator shall charge an excessive amount" for disinterring the body. The cemetery operator is also required to keep a separate register respecting "the particulars of every disinterment or removal of a body": s. 23(d). The *Health Act* also has regulations respecting the transportation of disinterred remains: N.S. Reg. 44/42, s. 4.

In some jurisdictions, the Chief Medical Examiner or Chief Coroner has authority to direct that a body by disinterred. In Alberta, the Chief Medical Examiner has this authority under Section 29(1) of the *Fatality Inquiries Act* for "the purposes of an investigation under this Act or the *Criminal*

Code (Canada)". Where the exhumation is for a purpose under the Alberta legislation, the family of the deceased, the Director of Vital Statistics, and the operator of the cemetery will receive a copy of an order of disinterment issued by the Chief Medical Examiner: s. 29(2). Where the purpose has to do with an investigation under the *Criminal Code* there is no duty to give notice: s. 29(3).

In Manitoba, either the minister responsible for the act or the Chief Medical Examiner may "order that the body by disinterred and may make such further order as may be required respecting the autopsy and the reburial of the body": s. 39(1).

12.2 Cremation

Under the *Vital Statistics Act*, where a deputy registrar has reason to believe he or she has encountered a suspicious death, there is an implicit duty to notify the medical examiner before issuing a certificate for burial or cremation. In Alberta, the *Fatality Inquiries Act* includes this direction:

> 16 (1) No person shall
>
> (a) cremate a body,
>
> (b) ship or take a body from a place in Alberta to a place outside Alberta, or
>
> (c) dissect a body or otherwise subject a body to study or research under section 58 of the *Universities Act*
>
> until a medical examiner or an investigator authorized by a medical examiner issues a certificate stating that he has examined the medical certificate of death.
>
> (2) A certificate issued under subsection (1) shall be in the form prescribed by the Chief Medical Examiner.
>
> (3) Notwithstanding subsection (1), in the case of foetal death in a hospital or in the case of the death of an infant under 28 days of age in a hospital, the hospital may dispose of the body in the manner prescribed in the regulations under the *Cemeteries Act*.

The Quebec statute offers this succinct clause:

> 78. In no case where notice must be given to a coroner pursuant to Chapter II may a dead body be buried or cremated in Quebec, transported out of Quebec or remitted in accordance with Division IX of the Public Health Protection Act (chapter P-35), except with the written authorization of the coroner.

This may be another area where clarification is needed between the *Vital Statistics Act* and the *Fatality Inquiries Act*.

13. CONCLUSION

This preliminary review of the *Fatality Inquiries Act* points to the need for revisions in the Act. At a minimum the roles and responsibilities of the Chief Medical Examiner, medical examiners, the Public Prosecution Service and other players require clarification. The relationship between medical examiners and the police ought to be specified and the process leading to the calling of inquests must be clarified. The perpetration of old practices in the Act has led to the abandonment of some procedures; some office holders assigned responsibility under the statute are no longer active.

It is also evident that a number of other statutes require amendment if they are to reflect existing practice. In particular, the relationships between the *Vital Statistics Act* and the *Fatality Inquiries Act* require review.

A goal for the legislation to be drafted following consultation with interested parties will be that it serve the needs of the community involved with a death, that is, the next-of-kin, the police, hospitals, funeral directors, universities, the office of Vital Statistics, and the public at large.[122]

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[122] Dr. Butt.

APPENDICES

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Appendix A, Table A
Non-disease related deaths: Nova Scotia, 1992-1995

Cause of death	1992	1993	1994	1995
Involving motor vehicle	**123**	**105**	**97**	**113**
Involving train	**0**	**1**	**0**	**1**
Involving water transport	**5**	**12**	**6**	**4**
Involving air and space transport	**0**	**1**	**1**	**3**
Accidental poisonings	**13**	**14**	**10**	**10**
Misadventures during medical care, abnormal reactions and late complications	**12**	**7**	**10**	9
Involving falls and fractures	58	73	80	95
Accident caused by fires and flames	29	27	15	13
Accidental drowning and submersion	7	16	11	7
Inhalation and ingestion of food or other object causing obstruction of respiratory tract or suffocation	13	7	20	11
Accident caused by handgun	0	0	0	1
Accident caused by all other and unspecified firearms	3	1	0	0
Accident caused by explosive material	15	0	1	0
Accident caused by electric current	6	1	0	0
All other accidents and late effects of accidental injury	23	24	23	28
Drugs, medicaments, and biological substances causing adverse effects in therapeutic use	1	0	0	1
Suicides	97	107	97	122
Deaths from assaults	21	17	14	16
Undetermined whether accidental or purposely caused – From poisoning by drugs, medicaments and biologicals, and from other solid or liquid substances	6	9	1	8
All other undetermined whether accidental or purposely inflicted	5	1	1	1
Total non-disease related deaths	438	423	388	443

Source: Nova Scotia, Business and Consumer Services, *Vital Statistics Annual Reports 1992,1993, 1994,1995*, Table X.

Appendix A, Table B
LeDain's 'independence" factors

	Security of Tenure	Security of Salary, etc.	Administrative independence
Auditor General under the *Auditor General Act*	• Appt. by GIC* • holds office during good behaviour; • may be removed from office for cause by the GIC on the passing by the House of Assembly of a resolution carried by a vote of 2/3 of members of the House • may be suspended for cause by GIC with support of Official Opposition and Pres. of Executive Council	• salary determined by GIC; paid out of Consolidated Fund • an employee within the meaning of the *Public Service Superannuation Act*	• supervises and responsible for all matters relating to the office • reports to GIC and the Assembly • makes annual report to Assembly
Chief Medical Examiner for Nova Scotia under the *Fatality Inquiries Act*	• Appt. by GIC • holds office during pleasure	• no reference though chief medical examiner for a county submits certified statement of fees & expenses to A.G.	• supervises medical examiners
Director of Public Prosecutions under *Public Prosecutions Act*	• Appt. by GIC after consultation with Chief Justice of N.S., Chief Justice of Trial Division and Executive of N.S. Barristers' Society; • holds office during good behaviour; • may be removed from office for cause by a resolution of the Assembly	• Status of Deputy Head and provisions of *Civil Service Act* apply; • paid same salary as Chief Judge of the Provincial Court	• head of public prosecutions service... conducts prosecutions independently of Attorney General • reports annually to Assembly in respect of prosecutions
Law Reform Commissioners under *Law Reform Commission Act*	• Members appt. by various groups, e.g. Barristers' Society, GIC, Dalhousie University • holds office for three years • ceases to hold office if he misses 3 meetings or composition of Commission is changed	• remuneration and expenses determined by GIC • Commission personnel appointed in accordance with *Civil Service Act* • appropriation for Commission comes from A.G.'s budget	• report from time to time to Attorney General and make annual report

	Security of Tenure	Security of Salary, etc.	Administrative independence
Utility and Review Board members under *Utility and Review Board Act*	• Appt. by GIC; • holds office on good behaviour	• Salary determined by GIC • Deemed to be member of public service for purposes of *Public Service Superannuation Act*	• Chair has responsibility for administration of the Board • Board prepares annual report on its activities with particulars as prescribed by GIC; A.G. tables it in the House

*GIC = Governor in Council – in practice, the cabinet of the government

Appendix A, Table C
Statutory duties of the Chief Medical Examiners for a Province or the Chief Coroner excluding any responsibilities respecting the conduct of inquests

	Nova Scotia statute	Alberta statute	Ontario statute	Newfoundland statute	Saskatchewan Law Reform Commission
1. to administer the Act <u>or</u> to operate the Act in relation to the reporting, investigating, and recording of deaths		s. 5(4)(a)	s.4(1)(a)	3(4)(a)	s.5(a)
2. to appoint physicians as medical examiners	to appoint medical examiners with the approval of Cabinet: s. 4(1)	appointed by Min. of Justice: s.7		s. 3(4)(b)	to make recommendations to cabinet [or Minister] respecting such appointments: s. 5(i)
3. to appoint medical investigators				s. 3(4)(c)	
4. to appoint an Acting Chief Medical Examiner who may act in the place of the Chief Medical Examiner				s. 3(4)(d)	
5. to assist coroners [medical examiners] in obtaining medical and other experts where necessary					s. 5(c)
6. to authorize autopsies		s.21(b)			

		Nova Scotia statute	Alberta statute	Ontario statute	Newfoundland statute	Saskatchewan Law Reform Commission
7.	to bring the findings and recommendations of coroners' juries to the attention of appropriate persons, agencies and ministries of government			s. 4(1)(d)		s.5(e)
8.	to conduct programs for the instruction of coroners in their duties			s.4(1)(c)		
or,	to educate persons required to perform functions under the Act: Alberta,);		s. 5(4)(d		s. 3(4)(f)	s. 5(d)
9.	to determine the qualifications for pathologists for the purposes of this Act					s. 5(f)
10.	to develop and maintain the facilities required		s.5(4)(c)		s. 3(4)(e)	
11.	to dispose of unidentified bodies		s.19		s.17	
12.	to direct a coroner or medical examiner to take possession of the body		s.21	s.15(2)		
13.	to direct a medical examiner to conduct an investigation		s.21		s.13	

	Nova Scotia statute	Alberta statute	Ontario statute	Newfoundland statute	Saskatchewan Law Reform Commission
14. [is responsible for] the inspection of medical certificates of death in all cases where burial permits are issued under the *Vital Statistics Act*		s.5(4)(e)			
15. to issue public reports					s.5(g)
16. to order disinterment for purposes of investigation under the Act or the *Criminal Code*		s.29(1)		s.23	
17. to prepare, publish and distribute a code of ethics for the guidance of coroners			s.4(1)(e)		s.5(h)
18. to recommend to Cabinet the suspension or removal of any coroner for misconduct, neglect of duty or inability to perform his duties or to remove a coroner and appointment another where chief coroner is of the opinion that the first coroner cannot continue			s.25(3) as amended by S. O. 1994, c. 27, s. 136(3);		s.5(j)

		Nova Scotia statute	Alberta statute	Ontario statute	Newfoundland statute	Saskatchewan Law Reform Commission
19.	to supervise, direct and control all medical examiners in the performance of their duties or to supervise medical examiners in the performance of their duties or to have general supervisory powers in respect to each chief medical examiner and each medical examiner for a county of the Province	s.2(6)	s.5(4)(b)	s.4(1)(b)	s.3(4)(b)	
20.	to take responsibility for the "planning of the system"			Ontario Law Reform Commission 1995 at p. 257		
21.	to apply to a judge for a warrant to enter a premises where the Chief Medical Examiner has reasonable grounds to believe the premises may "contain evidence related to the manner or cause of death"				s.12(4)	

		Nova Scotia statute	Alberta statute	Ontario statute	Newfoundland statute	Saskatchewan Law Reform Commission
22.	in respect of the calling of inquests	s.8 notify a Provincial Court judge of certain categories of deaths (as with all m.e.)	s.33(1) notify the Fatality Review board	see s.21 (where body destroyed); s.26(2) to review coroner's refusal to conduct; s. 25(2) re: multiple deaths	s.25(1) – recommend to Minister that public inquiry be held where CME is of opinion it is necessary for protection of public interest or in the interest of public safety	

Appendix A, Table D
Powers and Responsibilities of Medical Examiners in Selected Jurisdictions

	Nova Scotia statute	Alberta statute	Ontario statute	Newfoundland statute
Jurisdiction 1. take charge of body	s. 5(1)	s.23(1) "takes possession" at time of notification	s.15(1) coroner must issue warrant to take possession and to "view the body"	s.9(1) "takes possession" at time of notification
■ affix prescribed notice form to body, shroud ...		s.23(2)		s.9(2)
Investigation 2. investigate death	s. 5(1) 'make diligent inquiry'	s.20(1) – the five criteria	s.18(2) – 4/5 criteria	s.10(1) – the five criteria
■ carry out examinations of the body		s. 23(4)		S.9(4)
■ delegate certain powers to a legally qualified medical practitioner or a police officer		note role of investigators at s. 9	s. 16(3)-(4)	note role of investigators at s. 11
■ *not required to* investigate deaths caused by natural causes, and certain post-operative deaths		s. 20(5)		s. 10(1) – m.e. investigates where satisfied death occurred as in ss.5-8
■ proceed with investigation where body has been destroyed ... or is lying in place from which it cannot be recovered or is outside province			s. 15(5)	

	Nova Scotia statute	Alberta statute	Ontario statute	Newfoundland statute
3. enter premises where dead body is suspected to be and remove it	s.19(1) "without warrant"	s.22(1)(a) "without a warrant"	s.16(1)(b)	s. 12(1)(a)
■ enter any place from where m.e. has reasonable grounds to believe a body was removed		s. 22(1)(a) "without a warrant"	s.16(1)(b)	s.12(1)(a)
■ inspect any place where deceased was, or where coroner has reasonable grounds to believe the deceased was, prior to his or her death where coroner has reasonable and probable grounds that this is necessary for the investigation			s. 16(2)(a)	s.12(4) –CME applies to judge for warrant
■ inspect and extract information from any records or writings relating to the deceased or his or her circumstances and reproduce such copies as coroner believes necessary where coroner has reasonable and probable grounds that this is necessary for the investigation			s. 16(2)(b)	

	Nova Scotia statute	Alberta statute	Ontario statute	Newfoundland statute
■ inspect and copy medical records, i.e. diagnosis, record or information relating to a person receiving diagnostic and treatment services in a mental health centre; similarly of patients in hospitals, notwithstanding *Mental Health Act* or *Hospitals Act*		s. 22(3)		s. 12(2)(a) [no mention of legislation]
■ cordon off or secure the scene or area in which death under investigation occurred for up to 48 hrs. or more		s. 22(1)(c)		s. 12(1)(c)
■ take charge of wreckage where person has met death by violence in a wreck			s. 12(1)	
■ transfer an investigation to another coroner under certain circumstances		s.20(2)(a) "notify another m.e. ..."	s. 17	s.10(3) to "notify" another m.e.
4. take charge of any money or other personal property found on or near deceased or take possession of anything which may be related directly to death	s. 22	s. 22(1)(b) ["without a warrant"]	s. 16(2)(c)	s.12(1)(b)

	Nova Scotia statute	Alberta statute	Ontario statute	Newfoundland statute
5. deliver the personal property with an inventory to the RCMP or police , or, place seized items in custody of police officer	s.22	s.22(1)(b)	s.16(5)	[no reference to delivery to police for safekeeping: s. 18]
Post-mortems (autopsies) 6. perform autopsies	s.6(1)	if m.e. is a pathologist, s. 26		if m.e. is a pathologist, s. 14(1)
7. obtain assistance of another medical practitioner if necessary when performing autopsy	s. 6(3)	s.26 –may authorize an autopsy by pathologist	s.28(1) "order post-mortems .."	s.14(1) – may authorize an autopsy by pathologist
▪ order post-mortems outside Province			s. 14	
8. direct that tissue be removed	*Human Tissue Act*, s. 7	s.27		s.15
9. authorize extraction of pituitary gland	s. 20			
Experts 10. engage services of experts to aid in examination of the dead body, or any portion of it ...	s.7	s.22(1)(d) with approval of CME	s.15(4)	s. 12(2)(b) with approval of CME
Release of body 11. release body	s. 5(3)	s.23(5)		s.9(5)
▪ where body is unclaimed or unidentified		s. 19 duty of CME		duty of CME , s. 17

		Nova Scotia statute	Alberta statute	Ontario statute	Newfoundland statute
12.	notify Inspector of Anatomy that he has a deceased requiring burial or cremation at public expense	*Anatomy Act*, s. 5(1)			
13.	where body not required under *Anatomy Act*, "cause the body to be disposed of as in cases which do not come under this Act."	*Anatomy Act*, s. 5(3); s. 14 which states that an unclaimed body shall be cremated or buried at expense of municipality			
14.	return anything seized to person from whom it was seized or next of kin	[returned by RCMP, s. 22]	s. 22(2) [m.e. or peace officer]	s. 16(5)	s.18
■	destroy soiled or damaged clothing that was taken into possession with a body		s. 24		s.19
Reports					
15.	prepare a report setting out with results of investigation respecting cause and manner of death	s. 5(2)			
16.	file s. 5(2) report with Clerk of the Crown	s. 5(2)			
17.	make single report in case of multiple deaths by accident	s. 9			
18.	report suspected child abuse	s. 5(4) also under *Children and Family Services Act*, s. 24(1)			

		Nova Scotia statute	Alberta statute	Ontario statute	Newfoundland statute
19.	complete a medical certificate of death in accordance with *Vital Statistics Act* where m.e. has investigated a death ...	*Vital Statistics Act*, s. 12 [stillbirths]; s. 17(4)-(5) – complete a medical certificate in the prescribed form "upon the request of the funeral director ... and cause it to be delivered to the funeral director" where death occurs without medical attendance	s. 20(4)		s.10(4)
■	where a m.e. has investigated a death, he or she "may consent to a physician completing a medical certificate" and shall record particulars	see also *Vital Statistics Act*, s. 17(4)-(5)			s.10(5)-(6)
20.	make report to Registrar of Motor Vehicles respecting motor vehicle accident related deaths	*Motor Vehicle Act*, s. 98(8)			
	Additional reports				
■	keep a record of all deaths of which he or she is notified		s.20(3)		s.10(2)
■	report to CME all investigations being conducted and all investigations completed		s. 20(3); s. 30 includes records	s. 18(1) –completed investigations	s.10(2)
■	provide reports of investigation to adult next of kin or personal representative of deceased if requested		s.31 –duty of CME	s.18(2) – how, when, why, etc. +post-mortem findings available to next of kin	s. 24(2) – duty of CME

	Nova Scotia statute	Alberta statute	Ontario statute	Newfoundland statute
▪ record why a death was NOT investigated		s. 20(2)(b)		s.10(3)(b)
▪ record all cases reported where inquest is unnecessary			s. 18(2)	
▪ notify police and CME where of opinion that death involves an offense under the Criminal Code		s. 32		s. 27
Inquests 21. in respect of certain deaths, send notice to Provincial Court judge for consideration as to whether inquest should be held	s.8	in Alberta, it is the CME who notifies a Fatality Review Board of potential cases: see. s. 33	in Ontario, the coroner may issue a warrant for an inquest where he or she thinks it necessary: s. 19	in Newfoundland, CME makes recommendation to the Minister of Justice, s. 25
22. attend an inquest and give evidence	s. 15			
Fees 23. certify various fees in statements to A.G.	s. 28 (m.e.); s.21(transport of body); s. 24(experts); s.27 (medical practitioners: autopsy)			

Appendix A, Table E
Prohibitions: Actions prohibited without authorization or certification by medical examiners

		Nova Scotia statute	Alberta statute	Ontario statute	Newfoundland statute
1.	interference with body unless permitted by m.e. (coroner) or CME		s.17	s. 11	s.20
2.	shipment of body outside Province until m.e. or coroner's certificate is completed	*see* Health Act Regulations, N.S. reg 44/42	s. 16(1)(b)	s. 13(1)	s.21(b)
3.	embalming of deceased to be taken outside province until coroner's certificate completed	*see* Health Act Regulations, N.S. reg 44/42, s.3		s. 13(2)	
4.	cremation or disposal of a body not available for future examination until m.e. issues certificate	*Vital Statistics Act*, s. 21(1) prohibits burial or cremation without a burial permit	s.16(1)(a)		s.21(a)
5.	disposal of body brought into province, until m.e. issues certificate		s. 15		s.22
6.	dissection of body for research purposes, until m.e. issue certificate		s. 16(1)(c)		
7.	disinterment	*Health Act*, s. 5: requires written permission of "medical health officer for the place where the body is buried" or directed by A.G.	s. 29 duty of CME		s. 23 – duty of CME
8.	obstructing coroner or m.e. in carrying out duties	s.19(2) – in respect of access to, or removal of body	s.25	s.16(6)	s.28

Appendix A, Table F
Deaths to be reported to Medical Examiners or Coroners

Deaths due to	Jurisdiction
accident	Alberta, Manitoba; Saskatchewan Law Reform Commission, *Proposals for a New Coroner's Act*, 1984; *Standards for Inspection ... of a Modern Medicolegal Investigative System*, 1st ed. 1974.
culpable negligence	Nova Scotia
disaster	Quebec
homicide	Manitoba
medical related issues	*see* Medical Related Issues table
misconduct	British Columbia, New Brunswick, Ontario, PEI
negligence	N.S., Alberta, B.C., Manitoba, N.B., Ontario, PEI
obscure circumstances	Quebec
poisoning	Alberta, Manitoba also *Standards for Inspection ... of a Modern Medicolegal Investigative System*, 1st ed. 1974.
suicide	Alberta, British Columbia, Manitoba *Standards for Inspection ... of a Modern Medicolegal Investigative System*, 1st ed. 1974; Saskatchewan Law Reform Commission, *Proposals for a New Coroner's Act*, 1984;
violence	N.S., Alberta, B.C., N.B., Ontario, PEI, Quebec; *Standards for Inspection* ... 1974
Death occurs	
suddenly and unexpectedly	British Columbia, Ontario
suddenly of unknown cause	Manitoba , PEI
suddenly when in apparent good health	Saskatchewan Law Reform Commission, 1984
under "circumstances as may require investigation"	New Brunswick, Ontario
unexpected manner, in an	Alberta, Manitoba
unexplainedly	Alberta
unfair means, by	British Columbia, Ontario, PEI

Deaths due to	Jurisdiction
Death appears to be	
suspicious or under unusual circumstances	*Standards for Inspection ... of a Modern Medicolegal Investigative System*, 1st ed. 1974
undetermined cause, of	Nova Scotia
undue means, caused by	Nova Scotia
unnatural, that is "other than disease or sickness"	British Columbia, N.B., Ont., PEI Saskatchewan Law Reform Commission

Appendix A, Table G
Deaths involving medical matters

anaesthesia – where death occurs while under anaesthesia, or while recovering from anaesthesia or within 10 days [or time reasonably attributable to]	Alberta, Manitoba Saskatchewan Law Reform Commission, *Proposals for a New Coroner's Act*, 1984.
battery – where deceased's body contains a battery or other device containing a sealed, long-lived radio nuclide	Alberta
contagious disease which is a threat to the public	Manitoba *Standards for Inspection ... of a Modern Medicolegal Investigative System*, 1st ed. 1974.
improper or negligent treatment	Alberta
malpractice; or death associated with diagnostic or therapeutic procedures	British Columbia, New Brunswick, Ontario, PEI; also *Standards for Inspection ... of a Modern Medicolegal Investigative System*, 1st ed. 1974.
operative procedure or within 10 days of	Alberta, Manitoba, PEI
pregnancy or following in circumstances that might reasonably be attributable to also abortion	Alberta, B.C., Manitoba, Ontario *Standards for Inspection ... of a Modern Medicolegal Investigative System*, 1st ed. 1974.
stillbirth without presence of a medical practitioner	Northwest Territories also *Standards for Inspection ... of a Modern Medicolegal Investigative System*, 1st ed. 1974.
unattended person where deceased was "unattended by a practising physician" or deceased unattended "within 14 days prior to death" or person died from disease or sickness for which disease the deceased was not treated by a medical practitioner	Alberta, Manitoba *Standards for Inspection ... of a Modern Medicolegal Investigative System*, 1st ed. 1974 Saskatchewan Law Reform Commission, 1984 British Columbia, Manitoba, Quebec

Appendix A, Table H
Institutional Deaths to be reported to Medical Examiners or Coroners

Place where death occurs	Jurisdiction
charitable institutions	Ontario
children's residence (licensed to care for children)	Ontario
community care facility	B.C.
correctional institutions [note some refer only to "jails or prisons" as in N.S.]	N.S., Alberta, B.C., Manitoba, N.B., Ontario, PEI, Quebec; *Standards for Inspection...*
detention centres	Alberta
detoxification centres	N.B.
foster care	Quebec
hospital where person was transferred from a nursing home, old age home, psychiatric facility	B.C., Ont
hospital, where death occurs within 24 hours of admission from another institution [check wording]	Manitoba, PEI, Saskatchewan Law Reform Commission, 1984
nursing home	Ontario
old age home	Ontario
place, institution, or facility prescribed	Alberta, Manitoba
psychiatric facility, or place to which Mental Health Act applies	Alberta, B.C., Manitoba, N.B., Ontario, Quebec
rehabilitation centres	Quebec
residence which is licensed to operate as a residential institution or care facility	Manitoba
retarded persons home	Ontario
sheltered workshops	Quebec
training schools	Ontario
Young Offender institutions	Alberta, Ontario, Quebec

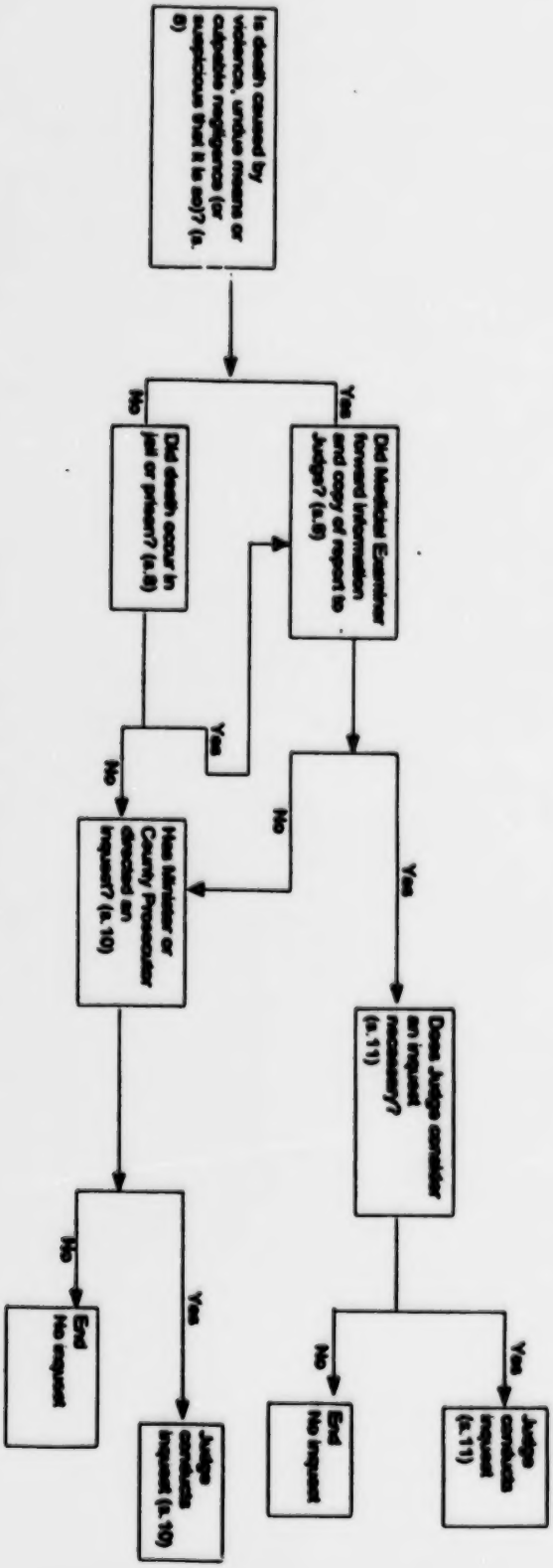
Appendix A, Table I
Deaths in particular places to be reported

Place where death occurs	Jurisdiction
construction project	Ontario
employment – where death is a result of contracting a disease or condition, sustaining an injury, or ingesting a toxic substance at the place of employment or former employment	Alberta, Manitoba
institutions	*see* Table 4
mining plant or mine including a pit or quarry	Ontario
police custody – person in custody of policy officer, or in legal custody	Alberta, B.C., Manitoba *Standards for Inspection ... of a Modern Medicolegal Investigative System*, 1st ed. 1974.

Appendix A, Table J
Deaths of particular persons to be reported to Medical Examiners and Coroners

Death of	Jurisdiction
children – where the deceased is a child; or where the child was under the guardianship of the director of Child Welfare	Manitoba Alberta, Quebec
Cree person in care or rehabilitation	Quebec
deceased is to be cremated, dissected or buried at sea	*Standards for Inspection* ...
deceased is unknown (i.e. identity not known) or, unclaimed	Quebec *Standards for Inspection* ... 1974
deceased is brought into jurisdiction for disposal; or without proper medical certification	Alberta *Standards for Inspection*...
where body is not located because (1) the body or part of the body has been destroyed; (2) the body is in a place from which it cannot be recovered; or (3) the body has been removed from the province	Saskatchewan Law Reform Commission, 1984

CHART - INQUEST UNDER *FATALITY INQUIRIES ACT*


Is death caused by violence, unfair means or culpable negligence (or suspicious that it is so)? (s. 6)
Yes
No
Did Medical Examiner forward information and copy of report to Judge? (s.8)
Did death occur in jail or prison? (s.9)
Yes
No
Yes
No
Has Minister or County Prosecutor directed an inquest? (s. 10)
Does Judge consider an inquest necessary? (s.11)
No
Yes
No
Yes
End No inquest
Judge conducts inquest (s. 10)
End No inquest
Judge conducts inquest (s.11)